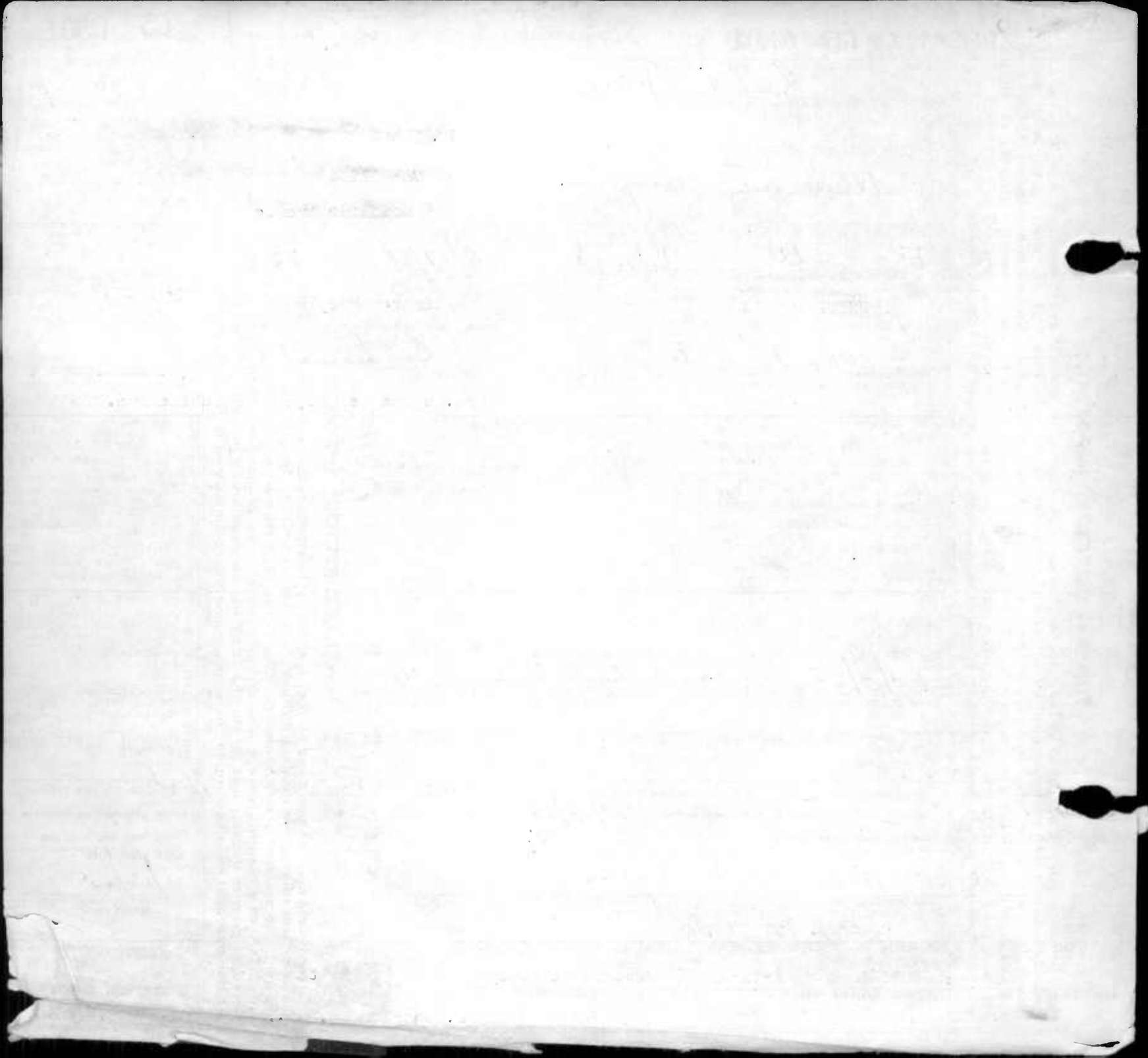


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

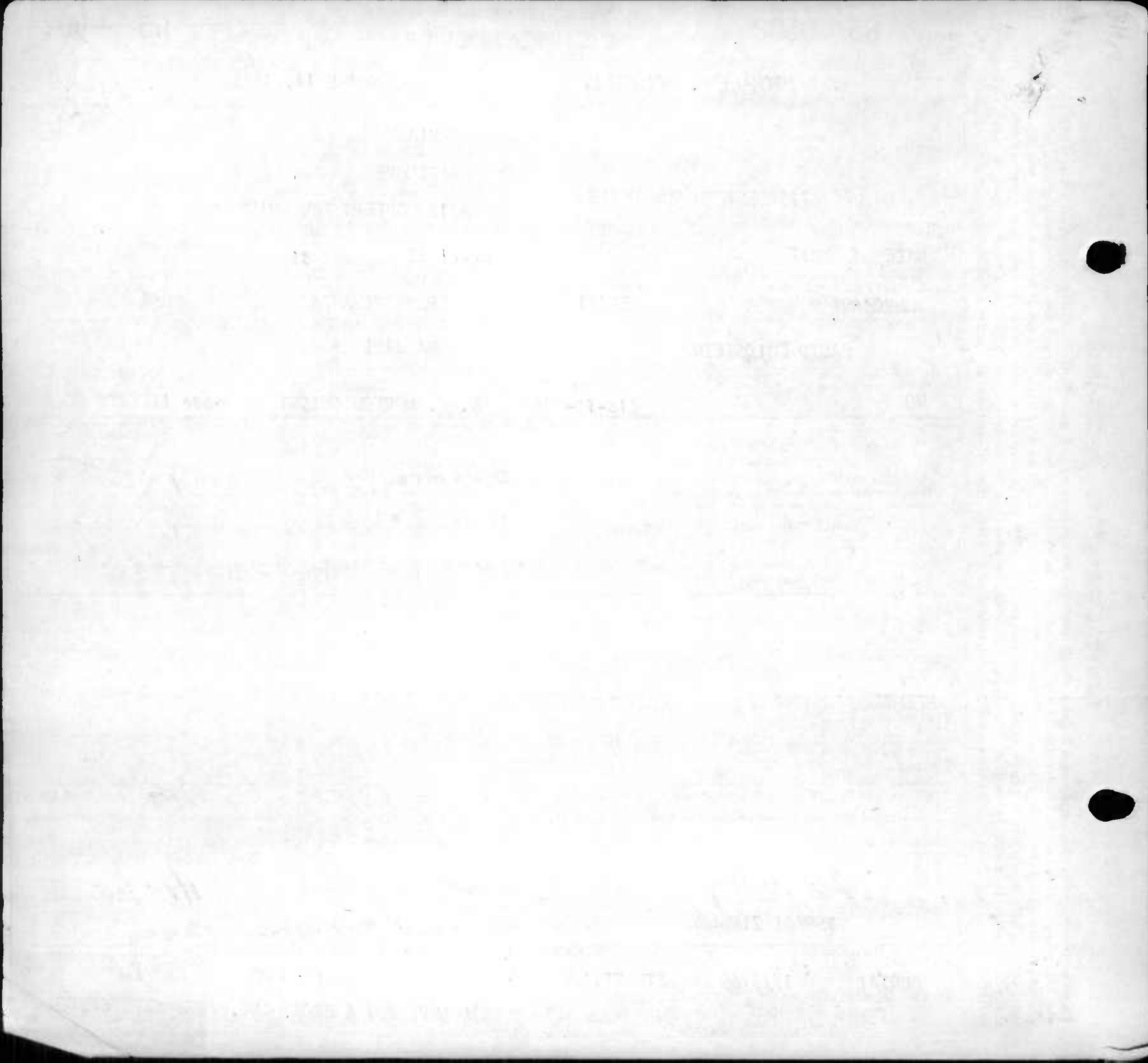
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0501	
BIRTH NO. 65 0501		M.E. CASE NO. KITTO		1. NAME OF DECEASED (Type or Print) Rachel L. Jones		2. DATE AND HOUR OF DEATH 1/13/65 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, give township) TOWSON 21204 D. STREET ADDRESS 616 Woodbine Avenue			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/27/88	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John T. Kitto			14. MOTHER'S MAIDEN NAME Catherine Evers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Eugene Leight, 6161 Woodbine Ave., TOWSON		
18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Carcinoma of sigmoid colon & Jejunum DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 1/12/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/4/65 19 65 to 1/13/65 19 65 , that (I) (we) last saw the deceased alive on 1/13/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce H. Mac Pherson M.D.						23B. DATE SIGNED 1/13/65	
23C. PHYSICIAN'S NAME (Type) Bruce H. Mac Pherson				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-15-65		24C. NAME of CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 15 1965		25B. NAME OF REGISTRAR R. E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Towson, Inc., 1050 York Road, 21204			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0502	
BIRTH NO. 65 0502		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MICHAEL H. GOLDSTEIN		2. DATE AND HOUR OF DEATH JANUARY 14, 1965 4:55 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 6713 WESTERN RUN DRIVE		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 27-20	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 6713 WESTERN RUN DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8/9/1883	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID GOLDSTEIN				14. MOTHER'S MAIDEN NAME RACHAEL ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-4756		17. INFORMANT ADDRESS MR. C. MORTON GOLDSTEIN 6606 LIBERTY ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Uremia		1 year	
				(B) DUE TO H A S H D		11 years	
				(C) DUE TO Coronary Insufficiency		2 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/22 19 64 to 1/14 19 65, that (I) (we) last saw the deceased alive on 1/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Israel Zinberg				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG				23D. ADDRESS 4000 W. Northern Pkwy			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/15/65		24C. NAME of CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 15 1965		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

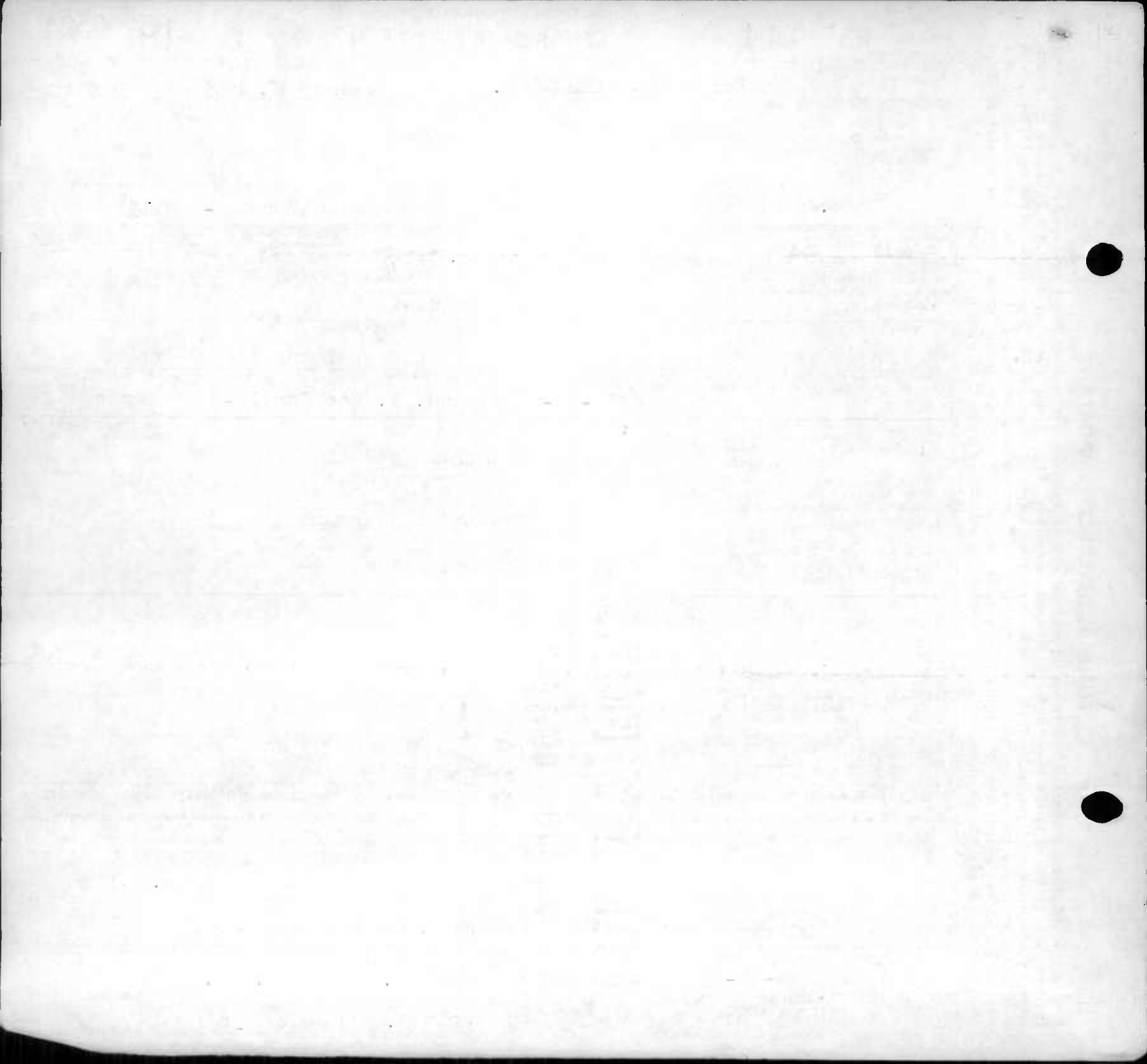
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0503				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 0503	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ETTA KATZENSTEIN				JANUARY 13, 1965 5:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
42 SINAI HOSPITAL				MARYLAND 27-20			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				3505 PINKNEY ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
FEMALE	WHITE	MARRIED		71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
MEYER LEWENSÖHN				ROSE PHILLIPS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				MR. EDGAR KATZENSTEIN 3505 PINKNEY ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		1 day	
ANTECEDENT CAUSES				(B) DUE TO		15 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO		4 years	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/1 1946 to 1/13 1965, that (I) (we) last saw the deceased alive on 1/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		1/14/65	
ISRAEL ZINBERG				M.D. 4000 W. Northern Pkwy			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1/15/65		HEBREW FRIENDSHIP		BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 15 1965		Robert E. Farley M.D.		SOL LEVINSON & BROS. INC.		6010 REISTERSTOWN RD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

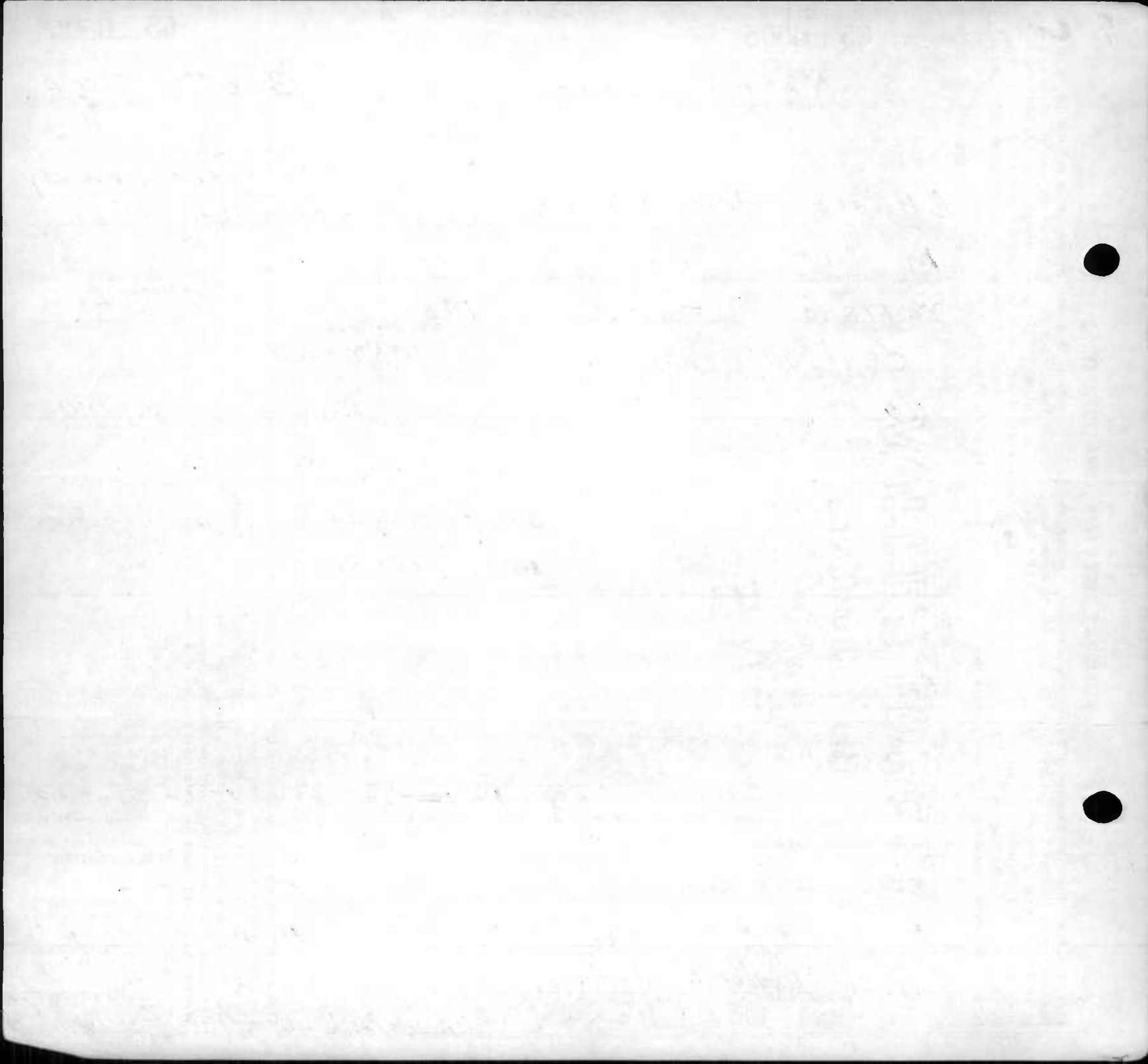
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 0504					CERTIFICATE OF DEATH					Registered No. 65 0504									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Mac CUBBIN, MARGARET M.					2. DATE AND HOUR OF DEATH January 12, 1965 3:00 A M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore					5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
FULL NAME OF HOSPITAL OR INSTITUTION 41 St. Joseph Hospital					6. STREET ADDRESS (If rural, give location) 3424 Ravenwood Avenue - 21213														
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Mar. 15, 1897		9. AGE (In years last birthday) 67		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					10B. KIND OF BUSINESS OR INDUSTRY Own home					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John Wesley Miles					14. MOTHER'S MAIDEN NAME Margaret Ann Coon														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 212-09-0757A					17. INFORMANT Wm. T. Mac Cubbin					ADDRESS 3424 Ravenwood Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction Pulmonary Edema					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH									
19. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from January 11, 1965 to January 12, 1965, that (I) lost saw the deceased alive on January 12, 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.																			
23A. SIGNATURE Salvador Marse					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED Jan. 12, 1965.									
23C. PHYSICIAN'S NAME (Type) Salvador Marse					23D. ADDRESS M.D. 1400 N. Caroline Street-21213														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1-15-64					24C. NAME of CEMETERY or CREMATORY Immanuel Lutheran Cem.					24D. LOCATION (City, town, or county) (State) Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 15 1965					25B. NAME OF REGISTRAR Robert E. Farber					25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

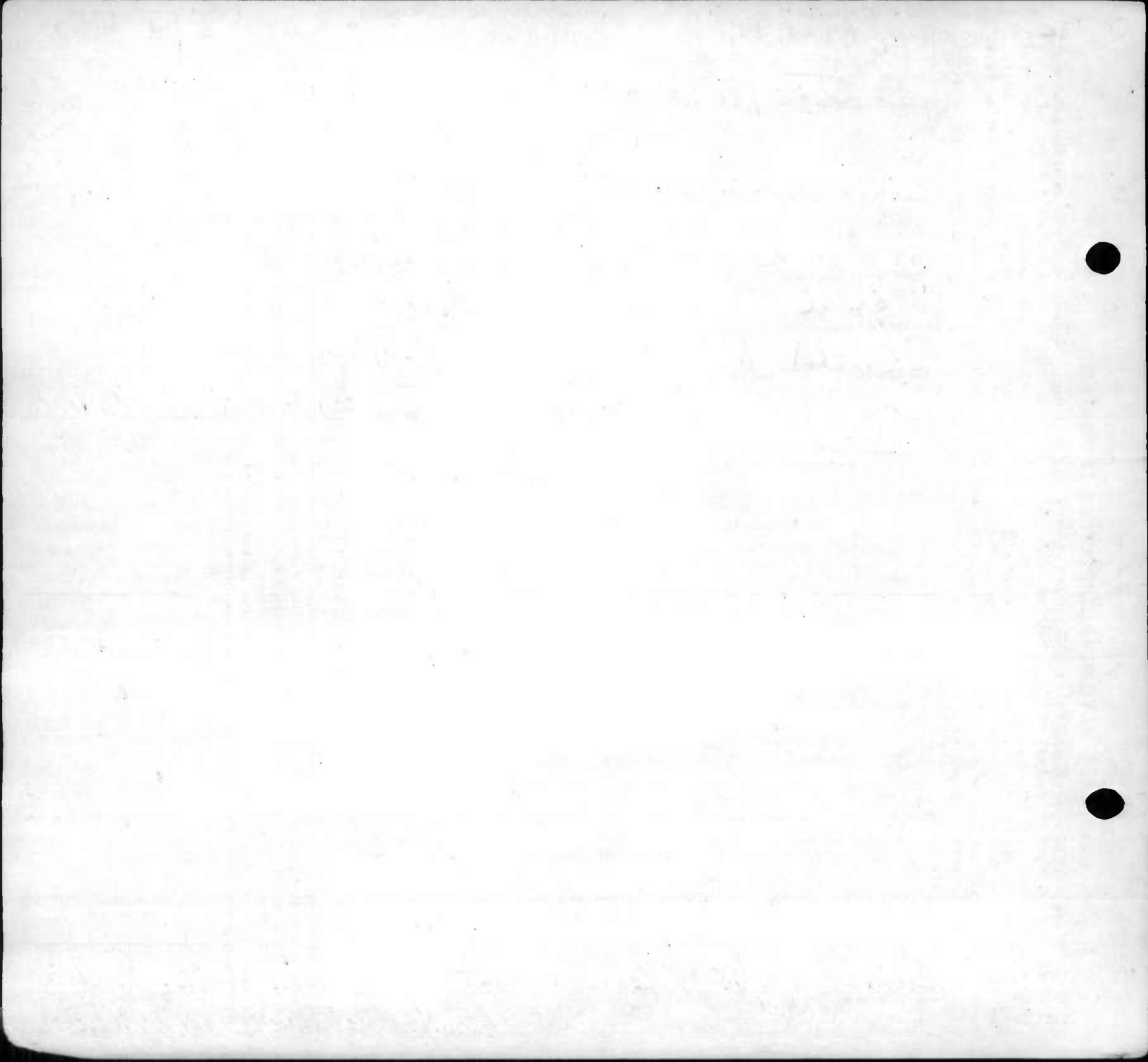
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0505	
BIRTH NO. 65 0505				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) NASH, WATSON			2. DATE AND HOUR OF DEATH 1-13-65 7:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH Home & Hospital			A. STATE MD B. COUNTY Balts.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) SPARKS, BALTIMORE COUNTY		
			D. STREET ADDRESS (If rural, give location) Cedar Grove Rd. 53-00		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-15-1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY Farmer		
11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Nash.			14. MOTHER'S MAIDEN NAME Unknown.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Robert Nash - Sparks MD.			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 960X I			CAUSE OF DEATH (A) Pneumonia, SEVERE DAYS (B) CHRONIC quadriplegia - 13 YEARS (C) AUTO ACCIDENT		
19. DATE OF OPERATION D			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1-11-1965 to 1-12-1965 , that (I) (we) last saw the deceased alive on 1-13-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga				23B. DATE SIGNED 1-12-65	
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA				23D. ADDRESS CHURCH Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 16/1965		24C. NAME OF CEMETERY or CREMATORY Cedar Grove Cemetery, Clarkston, Md.	
24D. LOCATION (City, town, or county) (State) Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Isaac Horstman, New Freedom, Pa.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

59-31489 65 0506		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 05062	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Tony Tyler</i>		2. DATE AND HOUR OF DEATH <i>1/11/65 8:35 PM</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		A. STATE <i>MD.</i> B. COUNTY			
5. SEX <i>M</i>		6. RACE <i>N</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NO</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSE</i>		8. DATE OF BIRTH <i>Oct 23 1959</i> 9. AGE <i>5</i> years (last birthday)	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Gerald Ringold</i>	
14. MOTHER'S MAIDEN NAME <i>Lillian Tyler</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Lillian Tyler 221 Silver St. Balto. Md.</i>		ADDRESS			
18. <i>165-X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cardiac arrest</i> DUE TO <i>thrombosis - 2nd to</i>		<i>Probably</i> <i>14 months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Replacement of lung tissue</i> DUE TO			
(C) <i>by metastatic carcinoma</i>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/31/64</i> 19 <i>64</i> to <i>1</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>1/11/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Geraldine K. Powell M.D.</i>				23B. DATE SIGNED <i>1/11/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Geraldine K. Powell</i>				23D. ADDRESS <i>Johns Hopkins Hosp - Dept of Pediatrics</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/16/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Pleasant Rest</i>	
24D. LOCATION (City, town, or county) (State) <i>Towson Balto. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>	
25C. FUNERAL DIRECTOR <i>John P. Bratman Jr.</i>		ADDRESS <i>1701 Mt. Cylloah St. Balto. Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0507	
BIRTH NO. 65 0507				CITY OF BALTIMORE	
M.E. CASE NO.				CITY OF BALTIMORE	
1. NAME OF DECEASED (Type or Print) CODY, JOHN JOSEPH			2. DATE AND HOUR OF DEATH JANUARY 14, 1965 8:40 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4402 OLD FREDERICK RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-4-92	9. AGE (In years last birthday) 72	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Robert Cody			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 215-07-9204		17. INFORMANT Martha Cody 4402 Old Frederick Road ST AGNES HOSPITAL RECORDS, WILKINS AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) LLL Pneumonia DUE TO (B) Diabetes Mellitus DUE TO (C) Cryptococcus? etiology		
19. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		INTERVAL BETWEEN ONSET AND DEATH
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1-4-19 65 to 1-14-19 65, that (I) (we) last saw the deceased alive on 1-14-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. J. Rodriguez</i>			23B. DATE SIGNED 1-14-65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D. ST AGNES HOSPITAL, BALTO. 29, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Robert E. Farley, M.D.		24F. FUNERAL DIRECTOR Ellsworth Armacost	
25A. DATE REC'D BY HEALTH DEPT. JAN 15 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Ellsworth Armacost	

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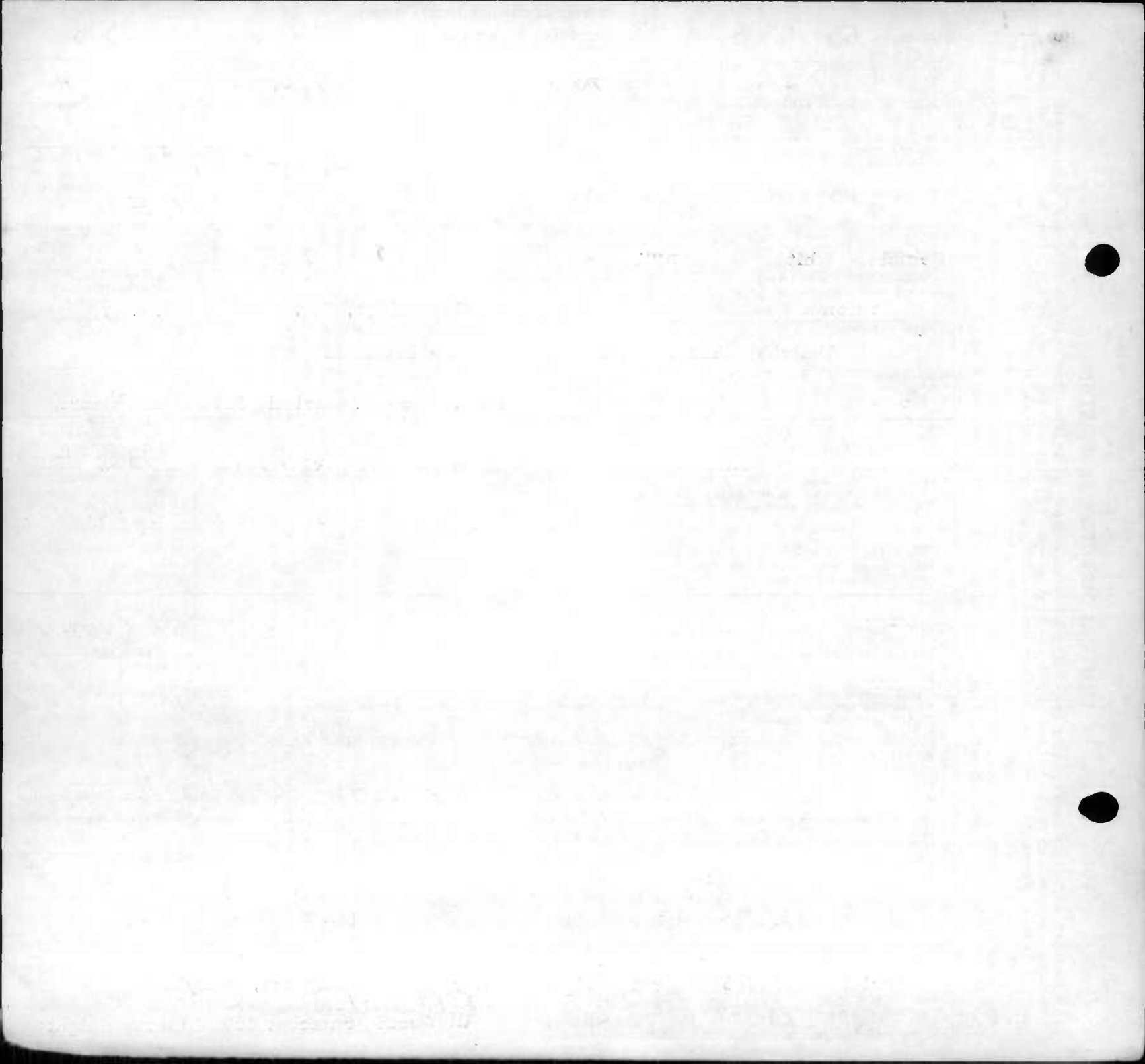
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100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0508		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0508	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Daisy - FRAMPON			
2. DATE AND HOUR OF DEATH 1/14/65 12:45 P M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL				A. STATE MD 8. COUNTY 27-18			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 4818 PARK HIGHTS #15			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) TWIDOWED		8. DATE OF BIRTH 11/2/89	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Paul				14. MOTHER'S MAIDEN NAME Lydia James			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs. Mary F. Christis 3102 Minna Court	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) UREMIC SYNDROME (B) SUSPECTED - NEPHROPHATIS UNKNOWN (C)		INTERVAL BETWEEN ONSET AND DEATH 48h +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETES - MELLITUS		UNKNOWN	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/8/65 19 to 1/14/65 19, that (I) (we) last saw the deceased alive on 1/14/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Any M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1/14/65			
23C. PHYSICIAN'S NAME (Type) BROON - ARY M.D.				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 15 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Ellisworth Armacost		ADDRESS 4600 Liberty Heights	



5-530

65 0509

BALTIMORE CITY HEALTH DEPARTMENT

65 0509

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO. 59300		1. NAME OF DECEASED (Type or Print) EMMA S. SMITH		2. DATE AND HOUR PRONOUNCED DEAD 1/12/65 4:15a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1204 W. North Ave.			
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 13, 1922	9. AGE (In years last birthday) 42	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Voc.		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Emory Tucker		14. MOTHER'S MAIDEN NAME Deana		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT John H. Smith		ADDRESS 2200 Presstman St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. NAME OF CEMETERY or CREMATORY		24. DATE REC'D BY HEALTH DEPT.			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		24D. ADDRESS	

MEDICAL CERTIFICATION

1940

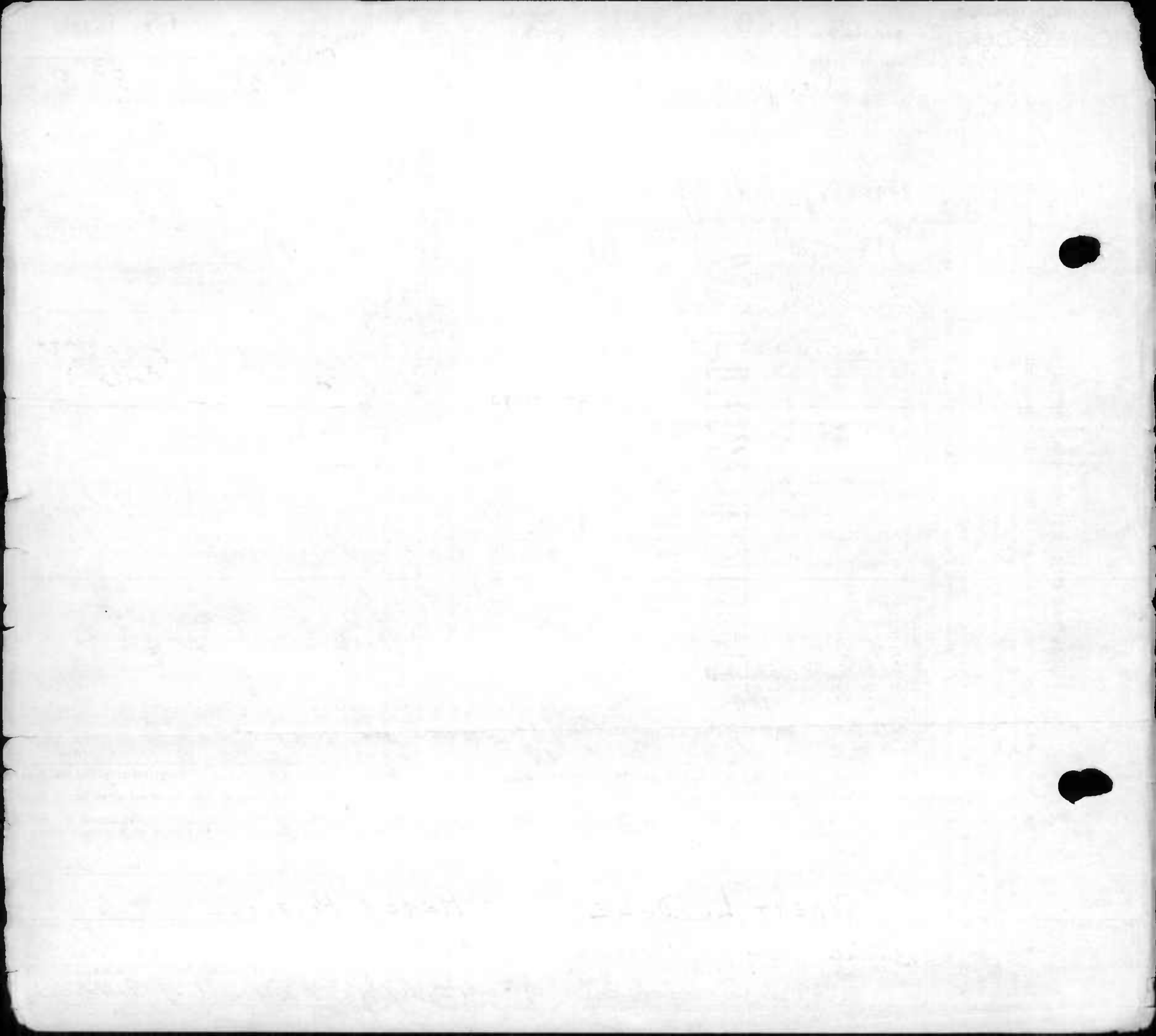
WILLIAM
RABBIT
ROCK



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0510	
BIRTH NO. 65 0510				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Casper Palermo</i>		2. DATE AND HOUR OF DEATH <i>1-14-65 8:30 P M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> 8. COUNTY <i>Balto.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 21 53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>21 Riverside Rd</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>7-26-03</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Braker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Thomas Palermo</i>		14. MOTHER'S MAIDEN NAME <i>Christine Passalacqua</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-01-6493</i>		17. INFORMANT <i>Wife (Same as above)</i>	
18. <i>581.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) <i>Staph. Septicemia</i>		<i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Infected Thrombophlebitis</i>		<i>4 days</i>	
		(C) <i>Thrombosis of Superior Vena Cava</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Liver Failure 2nd° to Cirrhosis</i>			
19A. DATE OF OPERATION <i>31-3-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cirrhosis</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>No</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>No</i>		21F. HOW DID INJURY OCCUR? <i>No</i>	
22. I certify that the (this hospital) attended the deceased from <i>12-9-64</i> 19 <i>64</i> to <i>1-14</i> 19 <i>65</i> . that he (we) last saw the deceased alive on <i>1-14</i> 19 <i>65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert L. Dgle</i>				23B. DATE SIGNED <i>1-15-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>ROBERT L. DGLE</i>				23D. ADDRESS <i>MERCY HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-18-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gardens of Faith</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Ind.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Connelly</i>		25D. ADDRESS <i>300 Mace Ave, Balto. 21</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0511</u>	
BIRTH NO. <u>65 0511</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Daniel W. Ackers</u>		2. DATE AND HOUR OF DEATH <u>1/13/65</u> <u>12:35</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>14-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1420 Druid Hill Ave.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>			
		D. STREET ADDRESS (If rural, give location) <u>1420 Druid Hill Ave.</u>			
5. SEX <u>m</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>1/3/84</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Porter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>store</u>		11. BIRTHPLACE (State or foreign country) <u>Ca.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>22001-5297A</u>		17. INFORMANT ADDRESS <u>Anita Ackers - 1420 Druid Hill Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>491X I</u>		CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1.10.1965</u> to <u>1.13.1965</u> , that (I) (we) last saw the deceased alive on <u>1.13.1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James D. Carr</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1.15.65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <u>1427 Madison Ave. - 17</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>1/18/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. B. Whitman Jr. - 1701 N. Calhoun St. Balto. md.</u>	

WATLEY ROAD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0512		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0512	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM JOHNSON		2. DATE AND HOUR OF DEATH 1/15/65 9:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 708 ENSOR STREET			
5. SEX M	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7/6/06	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LOUIS JOHNSON		14. MOTHER'S MAIDEN NAME MILLIE PEACOCK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 186-05-2197		17. INFORMANT MARY YOUNG 923 E. MADISON ST	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Esophagus		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none					
19A. DATE OF OPERATION 1/12/64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Esophagus		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/17/64 19 to 1/15/65 19 that (I) (we) last saw the deceased alive on 1/15/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Wagner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) JOHN WAGNER		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-18-65		24C. NAME OF CEMETERY or CREMATORY Mt CALVARY	
24D. LOCATION (City, town, or county) (State) a.a. COUNTY md		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR JOSEPH H. KNIGHT 1639 N. BROADWAY			

1940-41

1941-42

1942-43

1943-44

1944-45

1945-46

1946-47

1947-48

1948-49

SAB-42-42-4b

65 0513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0513

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

(AARO HAROLD LINDQUIST)

Aaro Lindquist

2. DATE AND HOUR OF DEATH

1-14-1965

11 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

8. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

706 South Rappolla Street, 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

XXXXX Widowed

8. DATE OF BIRTH

4-1-1901

9. AGE (In years
last birthday)

63

If Under 1 Yr.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

Lindquist

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

294

16. SOCIAL

SECURITY NO.

10 0185A

17. INFORMANT

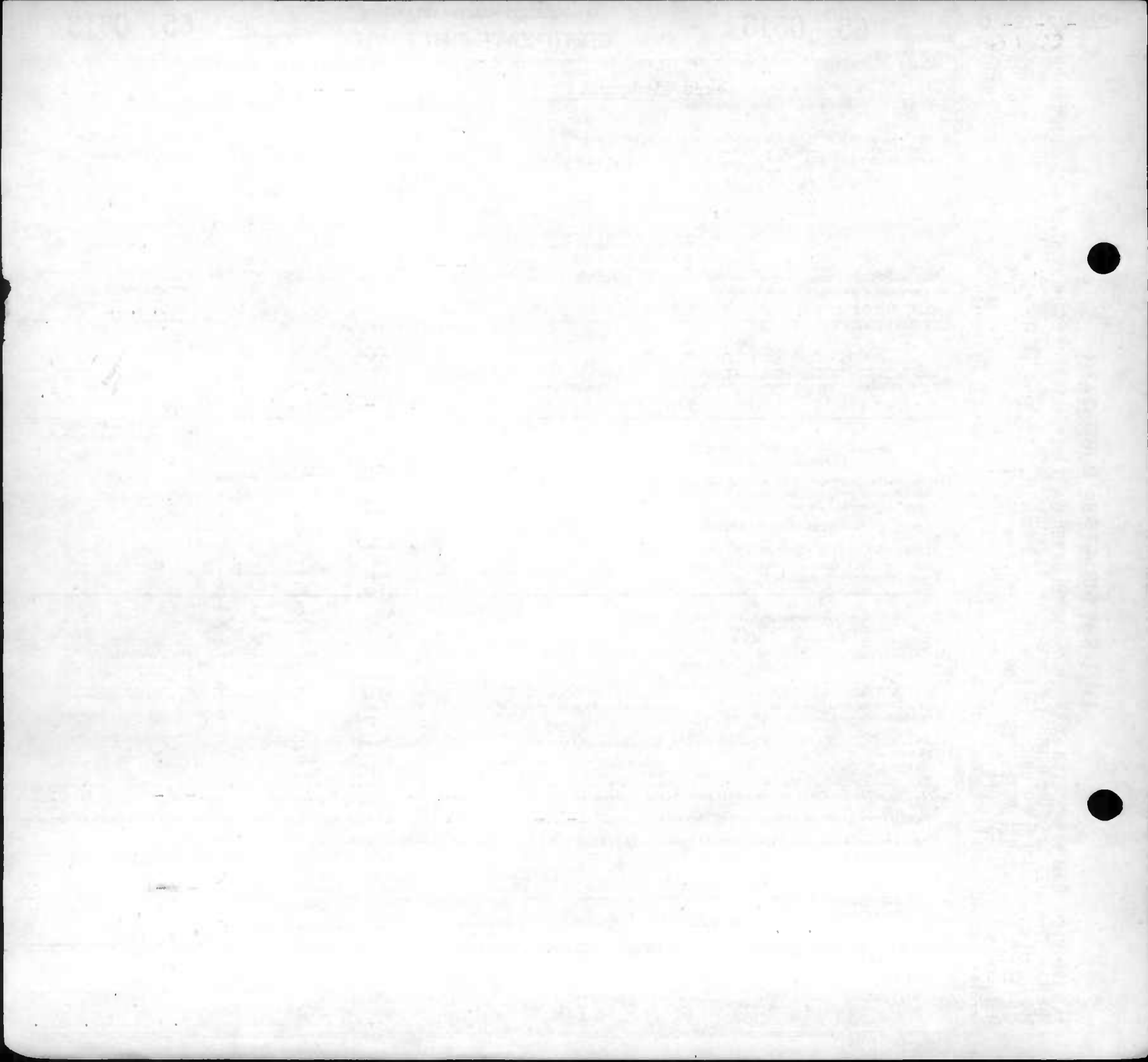
Mrs Laura L. Mathews Clarksville PA.
Records: BCH-4940 Eastern Avenue

ADDRESS

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Bronchogenic Carcinoma	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		DUE TO	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-21-19 64 to 1-14-19 65, that (I) (we) last saw the deceased alive on 1-14-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE	M.D. Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>
23B. DATE SIGNED	1-14-1965		
23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS		
Dr. H. Rathbun	M.D. 4940 Eastern Avenue, Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/65	Oak Lawn	Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1965	Robert E. Taylor, M.D.	Henfy Sander & Sons Inc. Balto. Md.	

FUNERAL DIRECTOR: IMPORTANT

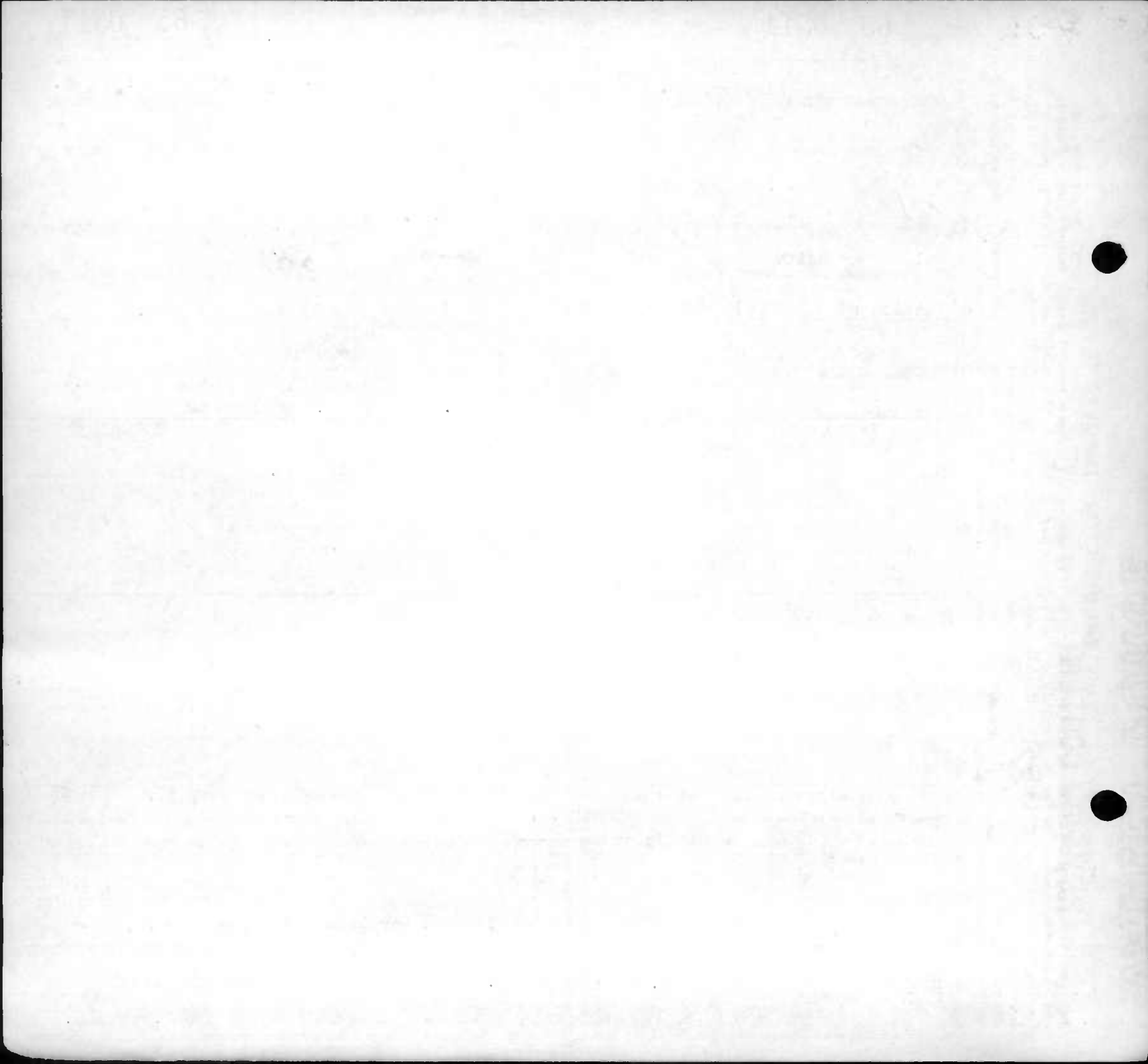
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0514	
BIRTH NO. 65 0514		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) (CHARLES WILLIAM SCHLUETER)		2. DATE AND HOUR OF DEATH January 17, 1965 8:30 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 41 St. Joseph Hospital		A. STATE Maryland B. COUNTY 103			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 700 S. Rose Street #24			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH May 3, 1910	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensioner (Clerk)		10B. KIND OF BUSINESS OR INDUSTRY Western Electric		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME John Schlueter		14. MOTHER'S MAIDEN NAME Elsie Mueller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 03 5739		17. INFORMANT ADDRESS 700 South Rose Street 21224 Mr. Herman F. Schlueter	
18. 5810 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cirrhosis of the liver. DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 28, 1964 to January 17, 1965 , that (I) (we) last saw the deceased alive on January 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jarad Lowfighe		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 17, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. 1400 N. Caroline Street, Balto. 13, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY St. Paul's Fifth Reformed	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC		ADDRESS BALTO.			

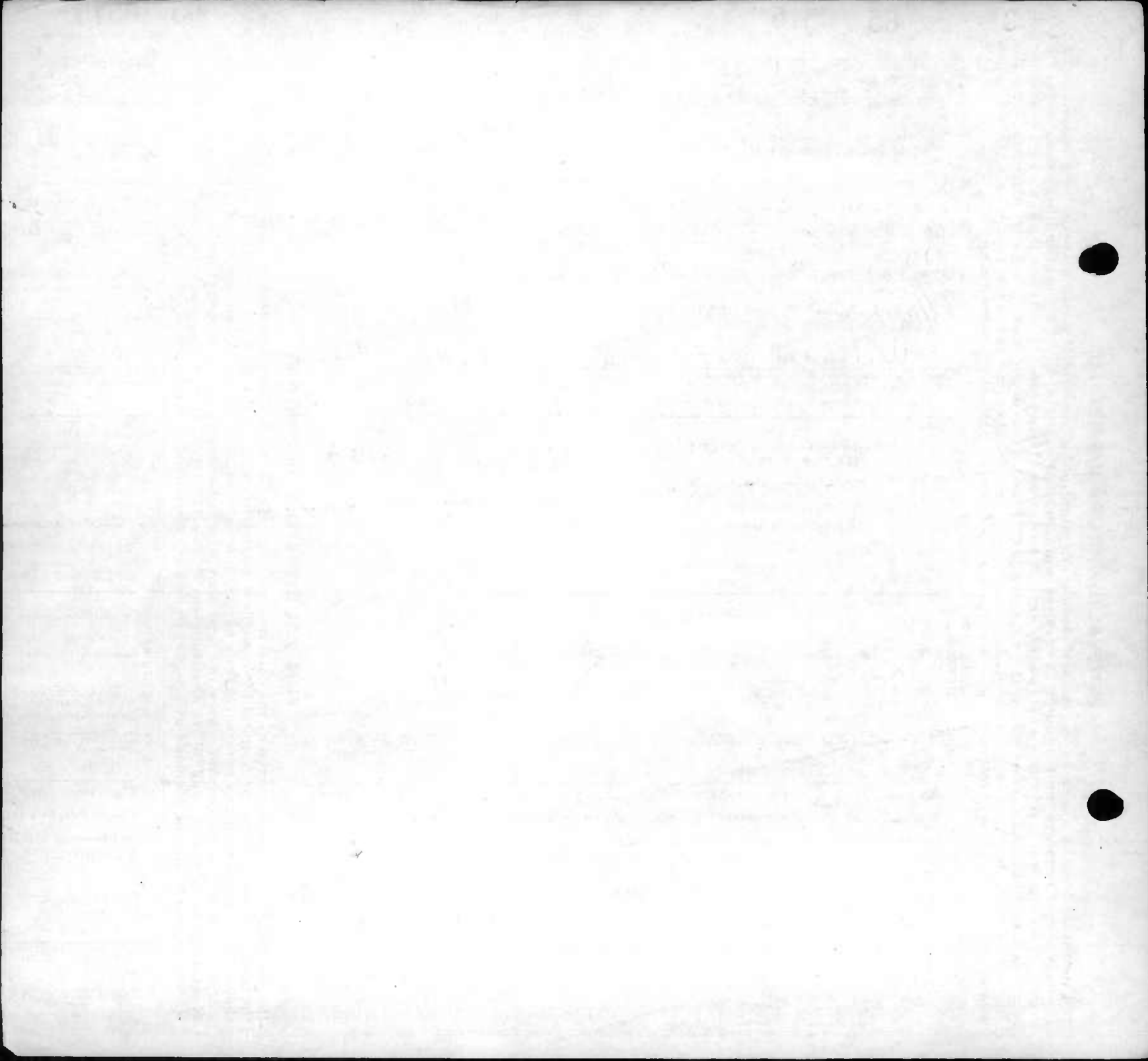


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W 5001

48

BALTIMORE CITY HEALTH DEPARTMENT				65 0515		65 0515	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				WILLIAM WILTON WANN		1/17/65 1:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL				A. STATE Md			
				B. COUNTY BALTIMORE			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 2401 Greenmount Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid	8. DATE OF BIRTH 3/29/09	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apprentice compositor Sun Papers		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md Towson Balto.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Wann				14. MOTHER'S MAIDEN NAME DORA ELLIOTT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War # 2 215				16. SOCIAL SECURITY NO. 03 1085		17. INFORMANT SISTER Mrs Dora E. Wann (Mother)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/14 1965 to 1/17 1965, that (I) (we) last saw the deceased alive on 1/16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Edward A Person				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/17/65	
23C. PHYSICIAN'S NAME (Type) Edward A Person				23D. ADDRESS Md. Genl. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE, MARYLAND			

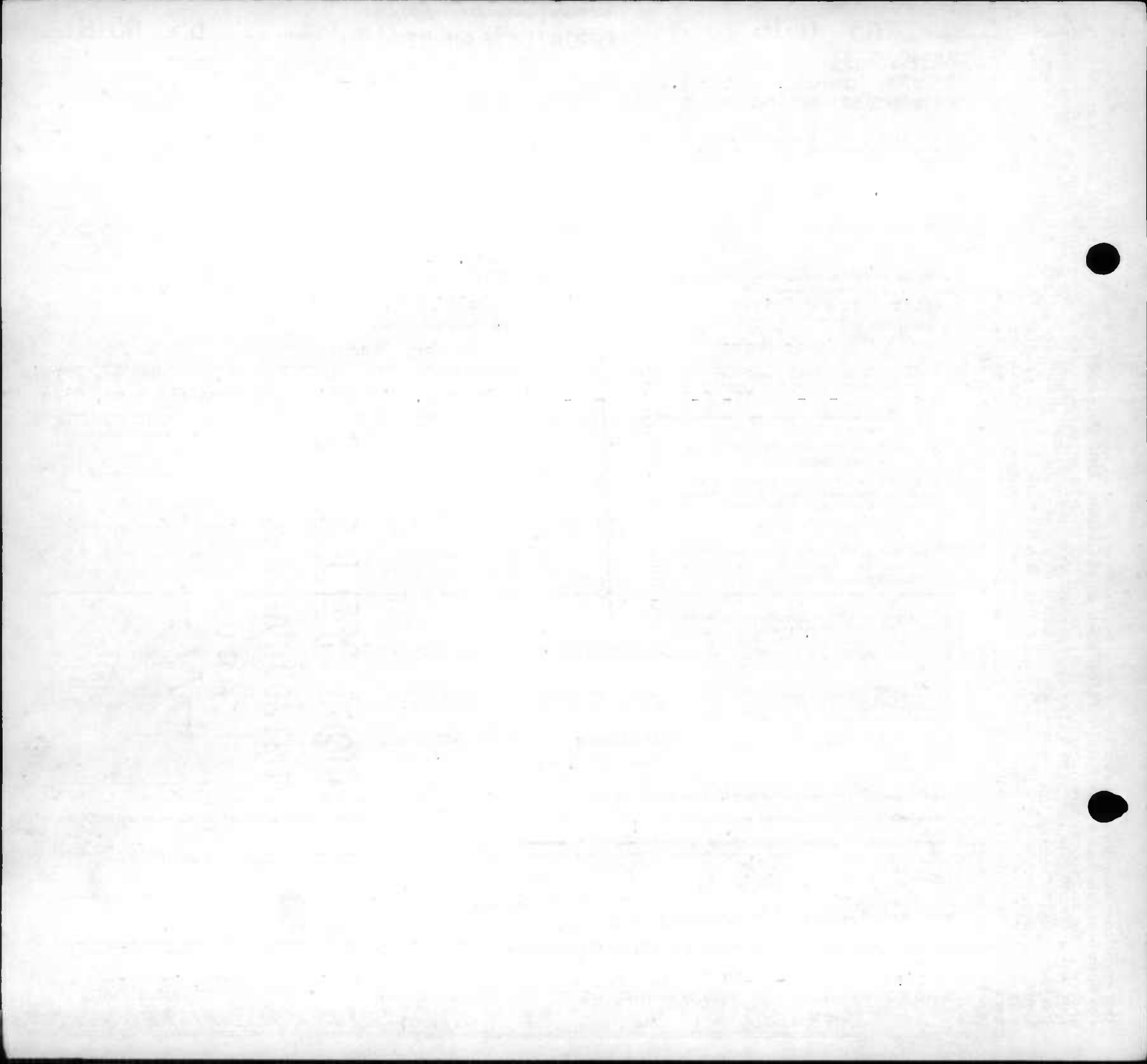


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 65 0516

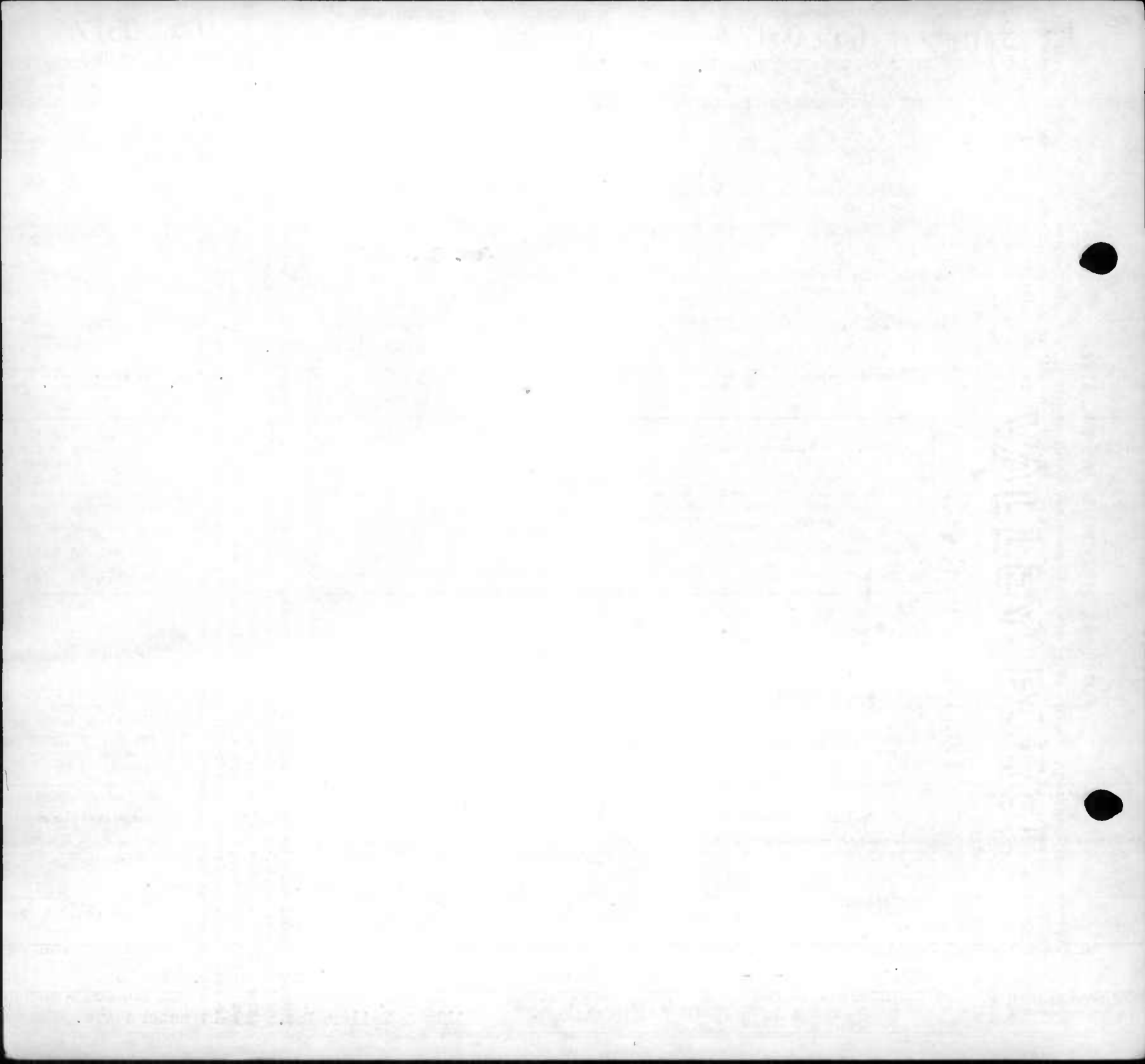
BIRTH NO. 65 0516		CERTIFICATE OF DEATH		Registered No. 65 0516	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dorman, Walter E.		2. DATE AND HOUR OF DEATH 1-15-65 9:28 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel Co. 9.9.C.		M.	
FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Ferndale 32-00		D. STREET ADDRESS (If rural, give location) 12 Ferndale Road	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH Aug. 6, 1889	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Dorman		14. MOTHER'S MAIDEN NAME Mary Stucke		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-28-18 12-12-18	
16. SOCIAL SECURITY NO. 213-28-6287		17. INFORMANT James L. Nieberline		ADDRESS 12 Ferndale Road, Glen Burnie	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Generalized peritonitis (B) Perforated duodenal ulcer (C) INTERVAL BETWEEN ONSET AND DEATH ? 72 hours ? 72 hours		MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 15 Jan 1965 to 15 Jan 1965, that (we) last saw the deceased alive on 15 Jan 1965 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-15-65		23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-1965		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Baltimore County, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 18 1965		24F. NAME OF REGISTRAR R. E. Farber	
24G. FUNERAL DIRECTOR Lilly & Keiser Inc 1901 Eastern Ave		24H. ADDRESS		24I.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

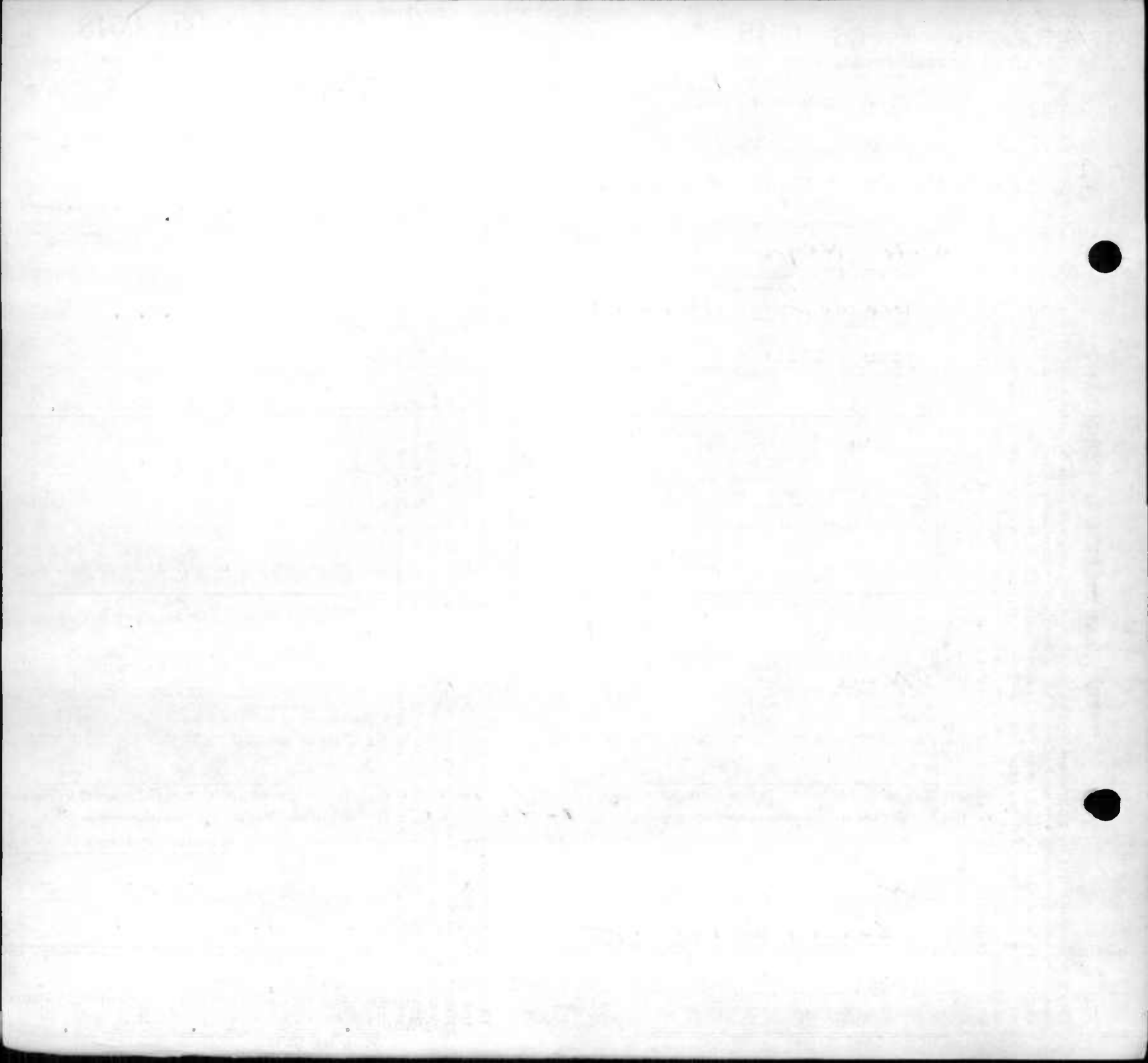
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0517	
BIRTH NO. 65 0517		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Mary V. Gerstbrich GERSTBRICH MRS MARY		2. DATE AND HOUR OF DEATH 15th Jan. 1965 1 3-30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital Baltimore 31, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 31 D. STREET ADDRESS (If rural, give location) 215 S. Maderia Street			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Jan. 30, 1883	9. AGE (In years last birthday) 81 yrs.	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME not known		14. MOTHER'S MAIDEN NAME not known	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Son, Francis Gerstbrich 215 S. Maderia St.	
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH phone-VE7-7700 ext. 43 (A) Acute myocardial infarction DUE TO cerebrovascular accident (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
19A. DATE OF OPERATION 1-15-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 1-15-65		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Church Home and Hospital, Balt-31 Md.	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1-15-65		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1-15-65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? 1-15-65		22. I certify that (if) (this hospital) attended the deceased from on 1-15-65 19 to 19, that (I) (we) last saw the deceased alive on 1-15-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Kishor C. Mehta M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED 1-15-65		23C. PHYSICIAN'S NAME (Type) KISHOR C MEHTA Dr. Mehta		23D. ADDRESS Church Home and Hospital, Balt-31 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-1965		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		25D. ADDRESS 1901 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

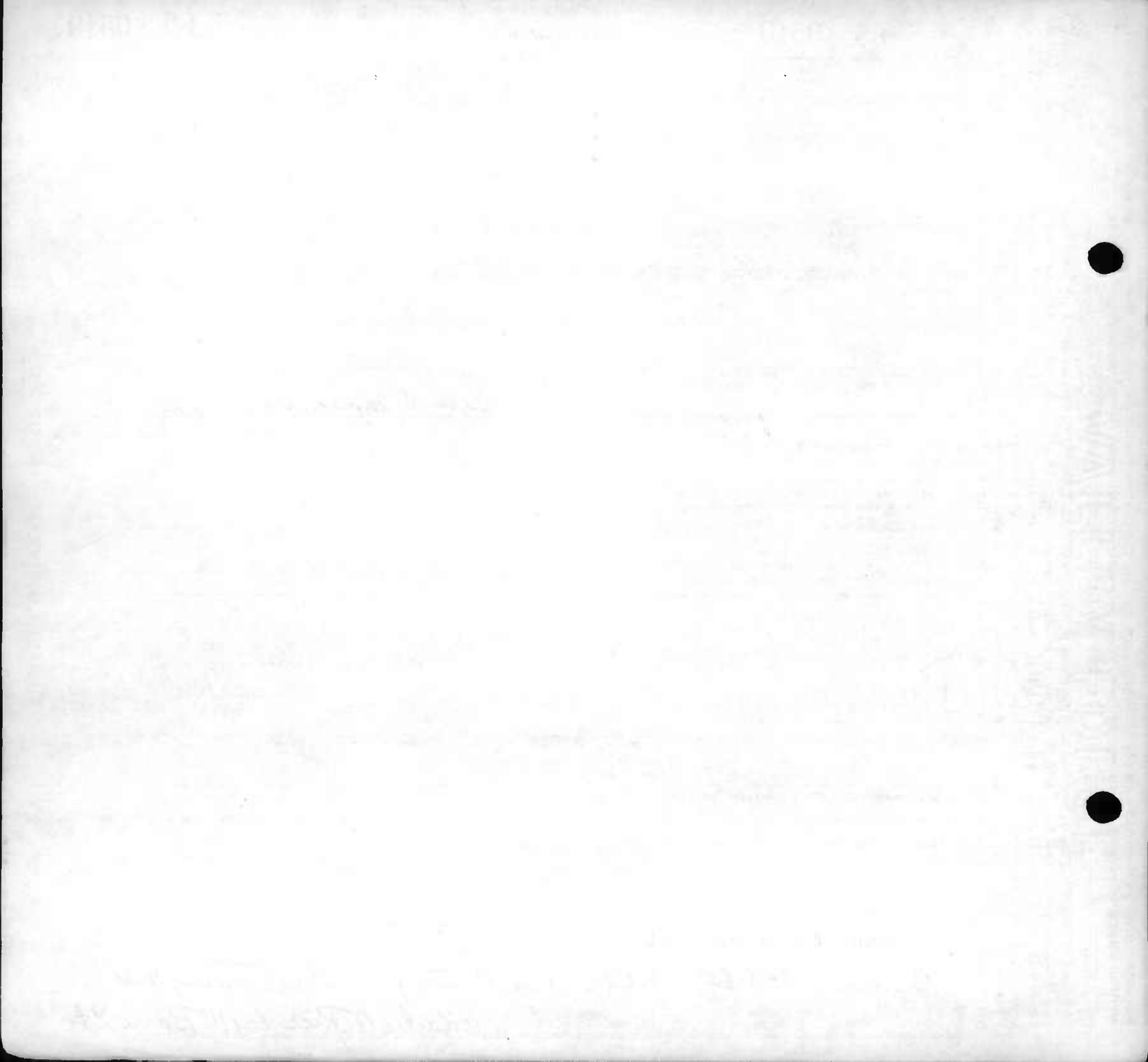
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0518	
BIRTH NO. 65 0518		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				LeRoy Tillman: LeRoy Tillman		1/14/65 9:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
1508 Poplar Grove Street				Maryland		16-07	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				1508 Poplar Grove St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.	
male	Negro			8/16/12	52		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Welder		Shipyard		North Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Tillman				Lena Ingram			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no				Pearlene Tillman		1037 Ashburton St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		16 days?	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Double pneumonia, pneumococcal Diabetes Mellitus		10 days 47 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1-6-61 19 to 1-14 1965, that (I) (we) last saw the deceased alive on 1-12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>Lucius W. Leeper</i> M.D.				1-15-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lucius W. Leeper				1200 S. Downingdale Rd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/18/65		Carver Memorial Park		Murkirk, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 18 1965		Robert E. Taylor M.D.		Charles A. Rice		661 W. Barre St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

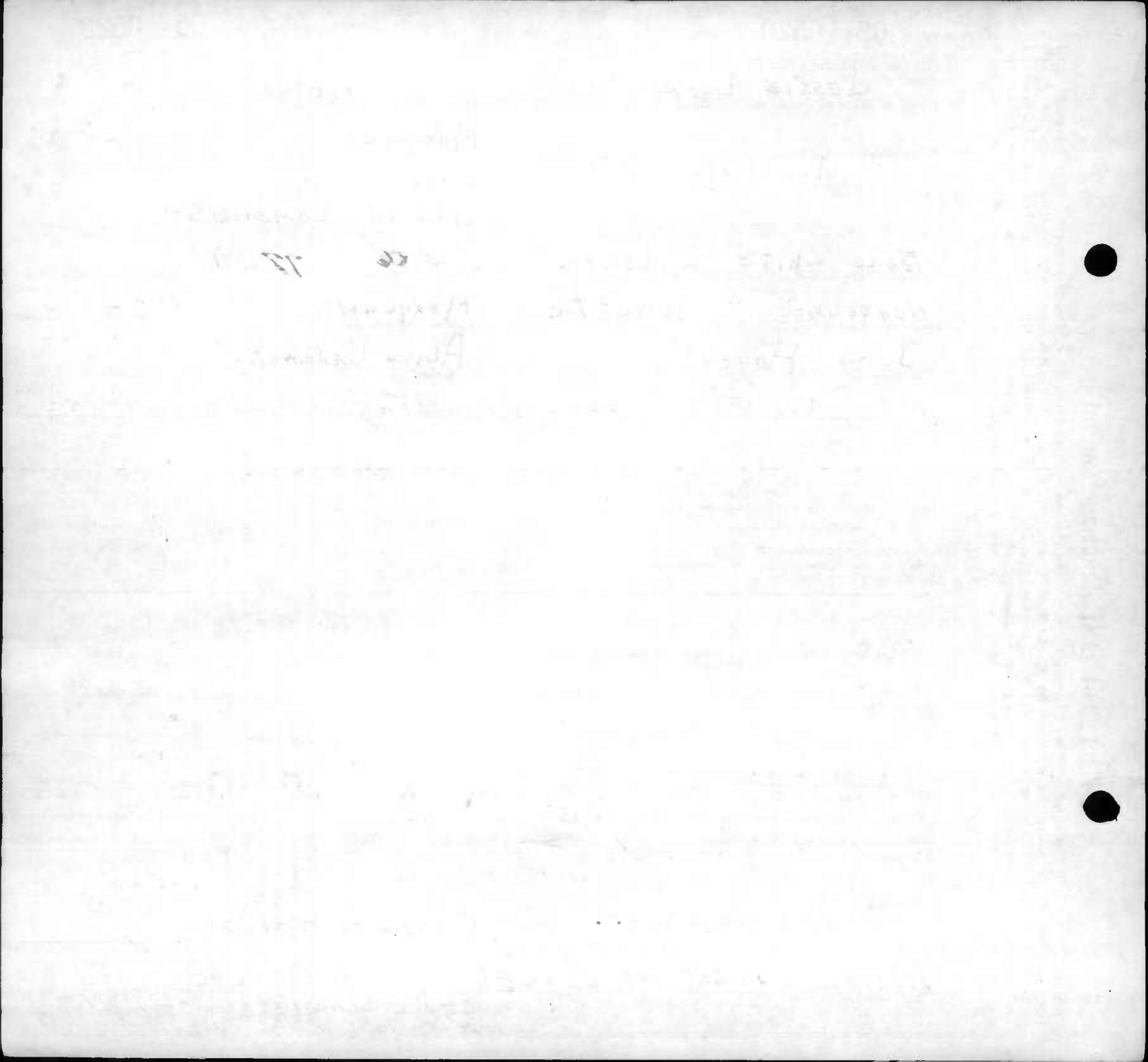
BIRTH NO. 65 0519				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0519	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>JAMES JOYNES</i>				2. DATE AND HOUR OF DEATH <i>JANUARY 15/65 2:50 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY <i>BALTIMORE</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
				D. STREET ADDRESS (If rural, give location) <i>623 ARCHER</i>			
5. SEX <i>M</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>5-1-95</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Car. Joynes</i>				14. MOTHER'S MAIDEN NAME <i>SILVIA</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Susie E. Joynes, 623 Archer St.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>420.111-7774</i>		CAUSE OF DEATH (A) DUE TO <i>Acute Myocardial Infarction</i> (B) DUE TO <i>ASCVD</i> (C)		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Abuse of Prostate</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>JANUARY 15 1965</i> to <i>JANUARY 15 1965</i> that (I) (we) last saw the deceased alive on <i>JANUARY 15 1965</i> and that in (my) (our) opinion death occurred on the date <i>2:50 AM</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kenneth Eugene Mott</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>January 15, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kenneth Eugene Mott</i>				23D. ADDRESS <i>University Hospital Baltimore Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-18-65</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles A. Rice, 661 W. Barre St.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0520	
BIRTH NO. 65 0520							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) JESSIE LYONS				2. DATE AND HOUR OF DEATH 11/15/65 3:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 20-03	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 1925 W. LOMBARD ST			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8/25/57	9. AGE (in years last birthday) 77 (77)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HAWK				14. MOTHER'S MAIDEN NAME ALICE LANCASTER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT AGNES TAYLOR		ADDRESS 1925 W. LOMBARD ST.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EMB				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC CONG. HT. FAILURE				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 11/15/65 to 11/15/65 that (I) (we) last saw the deceased alive on 11/15/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles H. Asplen				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/15/65	
23C. PHYSICIAN'S NAME (Type) CHARLES H. ASPLEN				23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-18-65		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert L. Taylor		25C. FUNERAL DIRECTOR GEORGE L. SCHWAB FRANCIS M. MILLER			



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65 0521
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00
Released by *Don Dedick Examiner*
THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

65 0521

CERTIFICATE OF DEATH

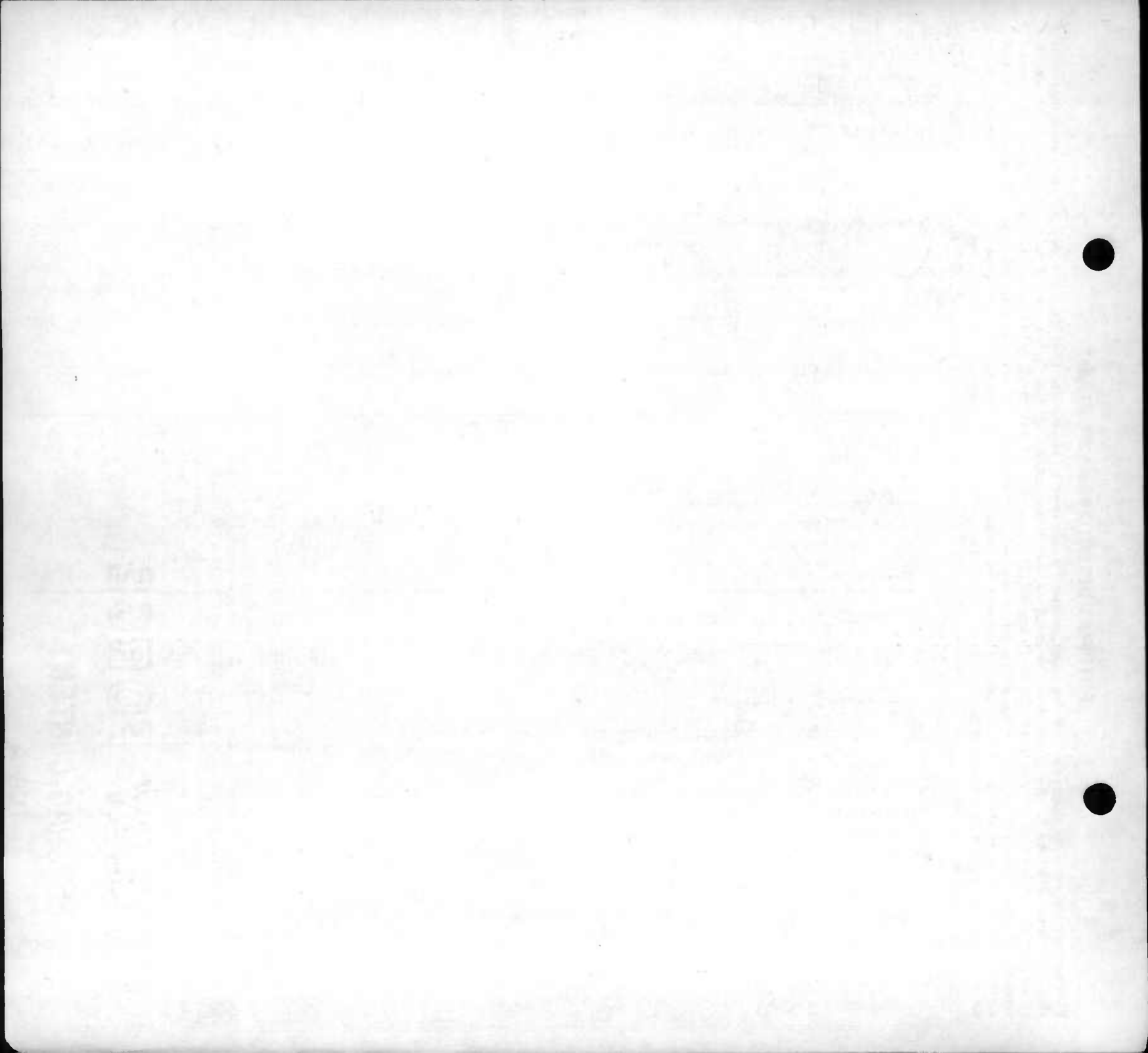
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CARROLL M. Rock</i>		2. DATE OF DEATH <i>JAN. 13, 1965</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>1041 WEDGEWOOD Rd.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>28-04</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
D. STREET ADDRESS (If rural, give location) <i>1041 WEDGEWOOD Rd.</i>		5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>MAY 5, 1916</i>		9. AGE (In years last birthday) <i>48</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PATTERN-Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Foundry</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>JAMES L. Rock</i>		14. MOTHER'S MAIDEN NAME <i>ANN HUGHES</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>2-03-3993</i>		17. INFORMANT <i>MRS. IRMA ROCK</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>420.11</i>		CAUSE OF DEATH (A) DUE TO <i>Coronary Thrombosis</i> (B) DUE TO <i>Rheumatic Heart Disease</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>8 yrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 12 - Jan. 13, 1965</i> to <i>Jan. 13, 1965</i> , that (I) (we) lost saw the deceased alive on <i>Oct. 23, 1964</i> and that in (my) (our) opinion death occurred at <i>10:45 P. m.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Earl L. Chamber</i>		23B. ADDRESS <i>4108 Liberty Hts</i>		23C. DATE SIGNED <i>1/15/65</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/18/65</i>		24C. NAME of CEMETERY or CREMATORY <i>LONDON PARK Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>G. TRUMAN SCHWAB</i>		ADDRESS <i>3512 FREDERICK AVE. (29)</i>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

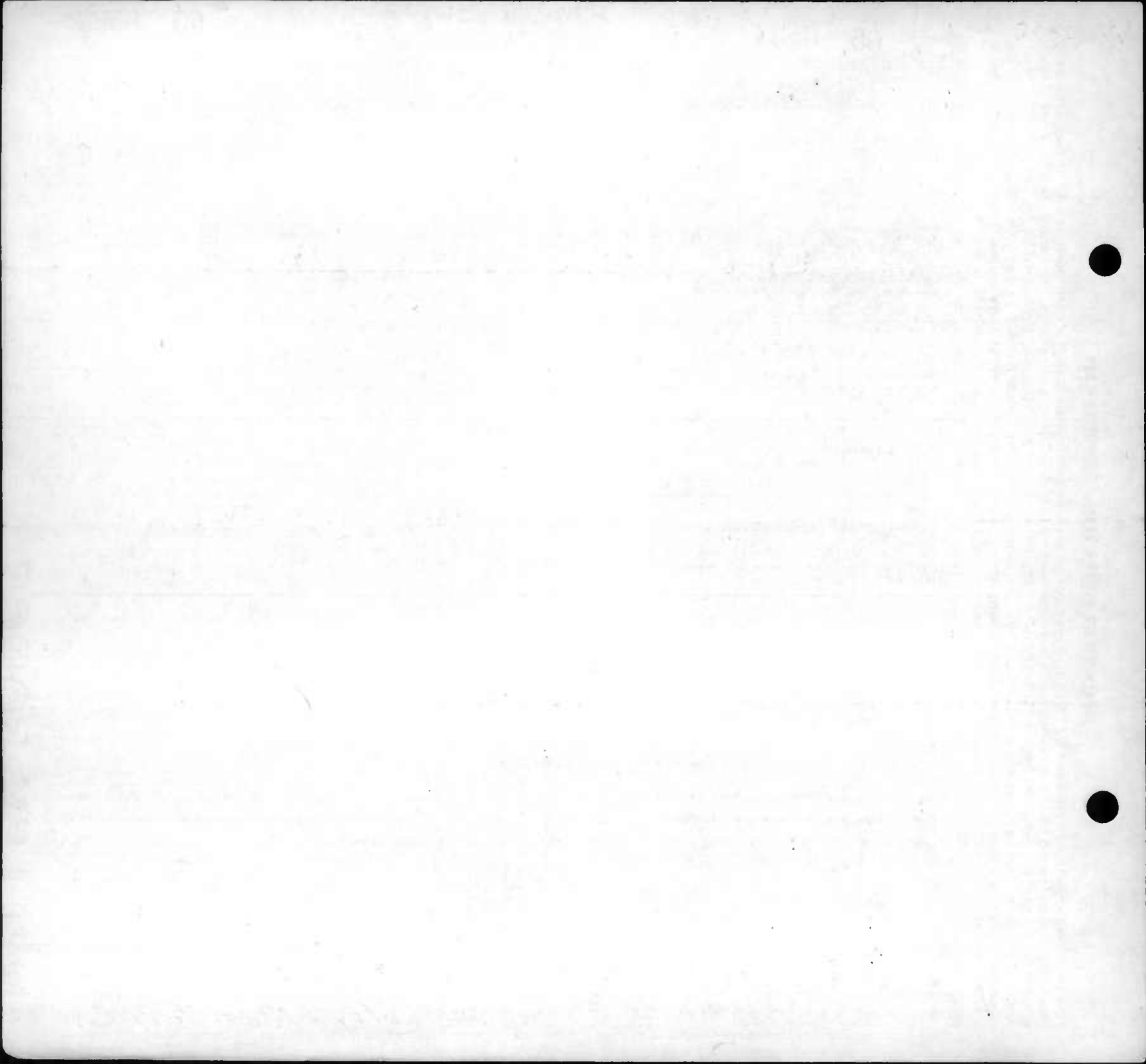
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0522	
BIRTH NO. 65 0522				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ALEXANDER Goldstein</u>		2. DATE AND HOUR OF DEATH <u>1/13/65</u> <u>1840</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI Hospital</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>3655 Cottage Ave.</u>	
5. SEX <u>M</u>	6. RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>420. N + 260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Cardiac arrhythmia</u> (B) DUE TO <u>Acute Pulmonary Edema</u> (C) <u>Coronary insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>35 min</u> <u>35 min</u> <u>> 1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>(1) Pulmonary tuberculosis</u> <u>(2) Diabetes mellitus</u> <u>(3) Cirrhosis</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8:05</u> <u>1/13</u> <u>1965</u> to <u>2:00 P.M.</u> <u>1/13</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>1/13</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Taylor</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/13/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Taylor</u>		23D. ADDRESS <u>SINAI Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-15-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>ROSEDALE</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Jack Lewis Inc</u>			
25D. ADDRESS <u>2100 E. Main St.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0523	
BIRTH NO. 65 0523				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WICKS, VIDA E.			2. DATE AND HOUR OF DEATH 1-16-65 6:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 7-01		
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W			8. DATE OF BIRTH 1-17-1892 9. AGE (In years last birthday) 72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W			11. BIRTHPLACE (State or foreign country) VIRGINIA		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARRY BYRD			14. MOTHER'S MAIDEN NAME EMMA MULLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HARRY WICKS "SANE"
18. 1-15-65 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Respiratory & cardiac arrest DUE TO (B) Generalized carcinomatosis DUE TO (C) a liver metastasis		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-11-65 19 to 1-16-65 19, that (I) (we) last saw the deceased alive on 1-16-65 6:05 A.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Romeo A. Ferrer				23B. DATE SIGNED 1-16-65	
23C. PHYSICIAN'S NAME (Type) ROMEO A. FERRER				23D. ADDRESS FRANKLIN SQ. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 1-19-65		24C. NAME of CEMETERY or CREMATORY Mt. Olivet	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE (State) MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Salisbury		25C. FUNERAL DIRECTOR ADDRESS 130 E. Fort St.	



FUNERAL DIRECTOR: IMPORTANT

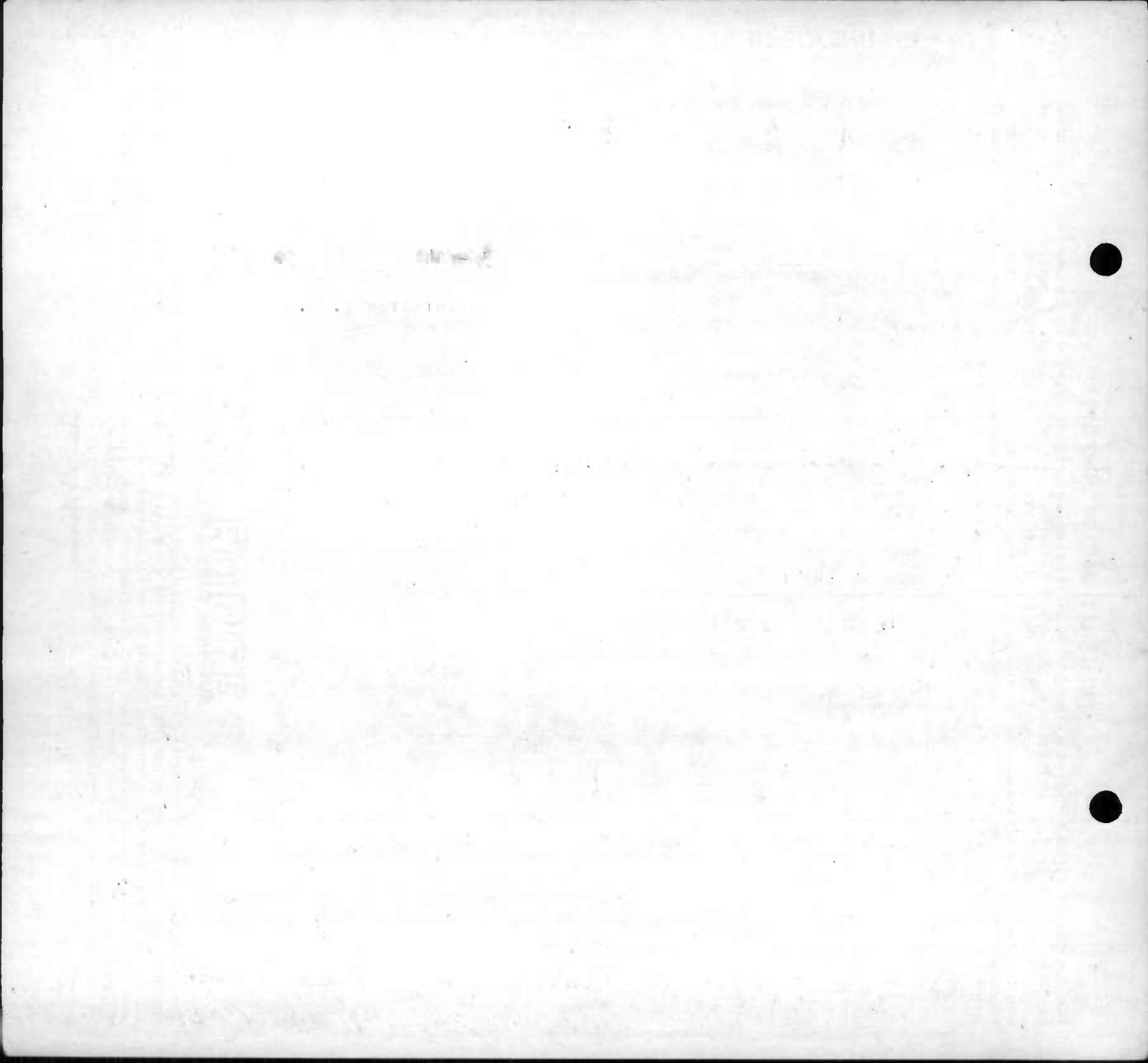
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0524					CERTIFICATE OF DEATH					Registered No. 65 0524				
1. NAME OF DECEASED (Type or Print) LITTLE, ELEANOR ELIZABETH					2. DATE AND HOUR OF DEATH 1-16-65 12:30A M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD									
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL EMERGENCY ROOM					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKBRIDGE					D. STREET ADDRESS (If rural, give location) 5421 MAIN STREET				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED NEVER MARRIED		8. DATE OF BIRTH 12-19-04		9. AGE (In years lost birthday) 60		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10B. KIND OF BUSINESS OR INDUSTRY ---					11. BIRTHPLACE (State or foreign country) MARYLAND				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME THOMAS LITTLE					14. MOTHER'S MAIDEN NAME (Rosa) ROSE STRUBEN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---					16. SOCIAL SECURITY NO. 215054441					17. INFORMANT ADDRESS ST. AGNES RECORDS--CATON & WILKENS AVE				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebro-vascular accident complicating severe hypertensive crisis. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH					19A. DATE OF OPERATION 10-17-64					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from JANUARY 15 19 65 to JANUARY 16 19 65, that (I) (we) lost saw the deceased alive on JANUARY 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Raphael Marin										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/16/65		
23C. PHYSICIAN'S NAME (Type) RAPHAEL MARIN										23D. ADDRESS M.D. ST. AGNES HOSPITAL BALTIMORE MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Jan. 19/65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.				24D. LOCATION (City, town, or county) (State) Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR Philip Herwig, Inc.				ADDRESS 2020 Calver St.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

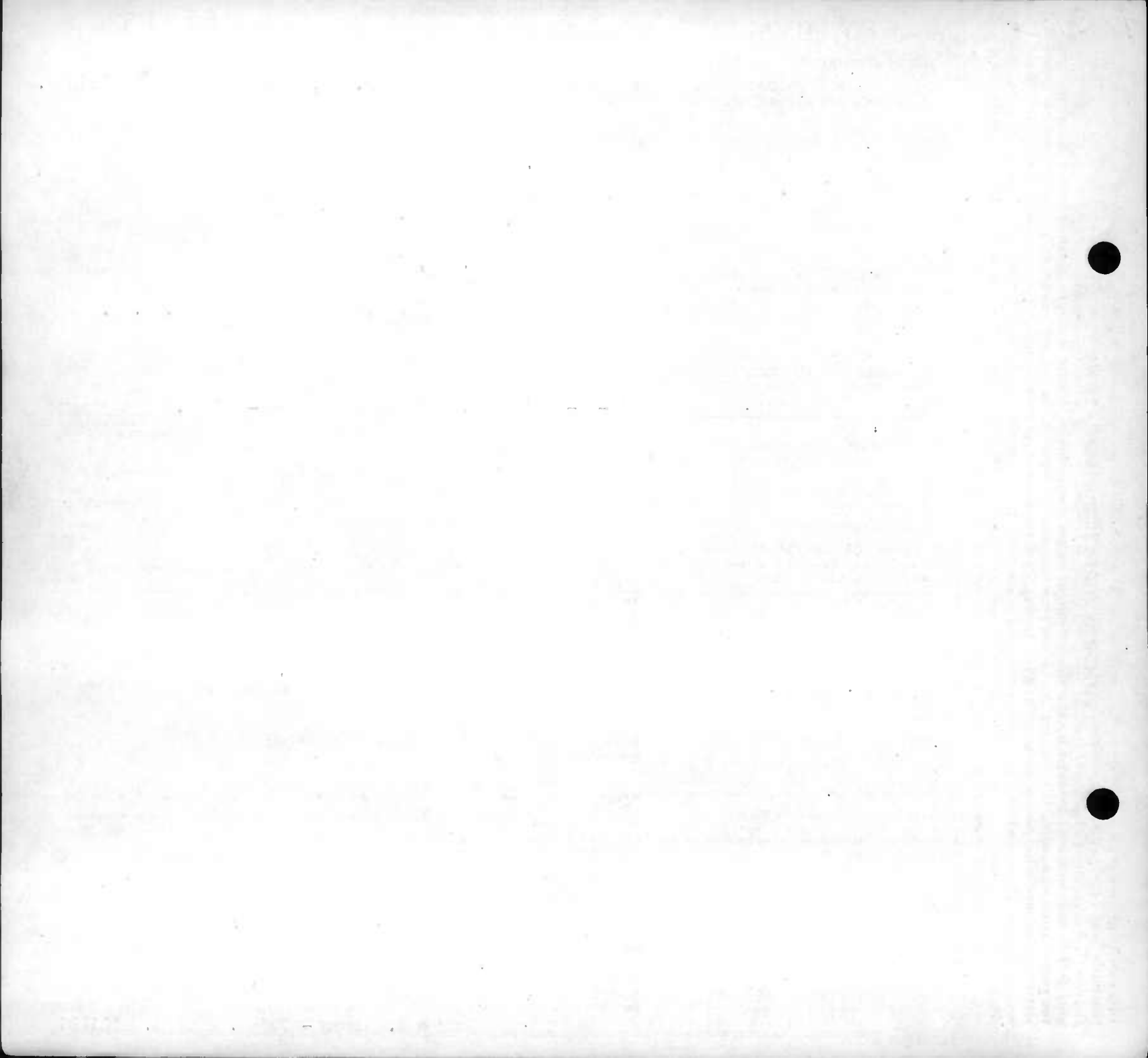
BIRTH NO. 65 0525		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0525	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Irene Ricketts		2. DATE AND HOUR OF DEATH 1/17/65 3:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 751 GEORGE STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOW	8. DATE OF BIRTH 3/9/14	9. AGE (In years last birthday) 50	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON D. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES JOHNSON		14. MOTHER'S MAIDEN NAME LULA JOHNSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 175101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Disseminated Papillary adenocarcinoma DUE TO (B) probably primary in ovary DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ? 6 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Cardiovas. disease		Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/24 1964 to 1/17 1965, that (I) (we) last saw the deceased alive on 1/17 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Willis C. Maddrey		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/17/65	
23C. PHYSICIAN'S NAME (Type) WILLIS C. MADDREY		23D. ADDRESS Johns Hopkins Hosp. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION Glen Burnie Md.		24E. NAME OF REGISTRAR Robert E. Fisher		24F. FUNERAL DIRECTOR John P. Carroll - 2400 Lakeside Ave.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

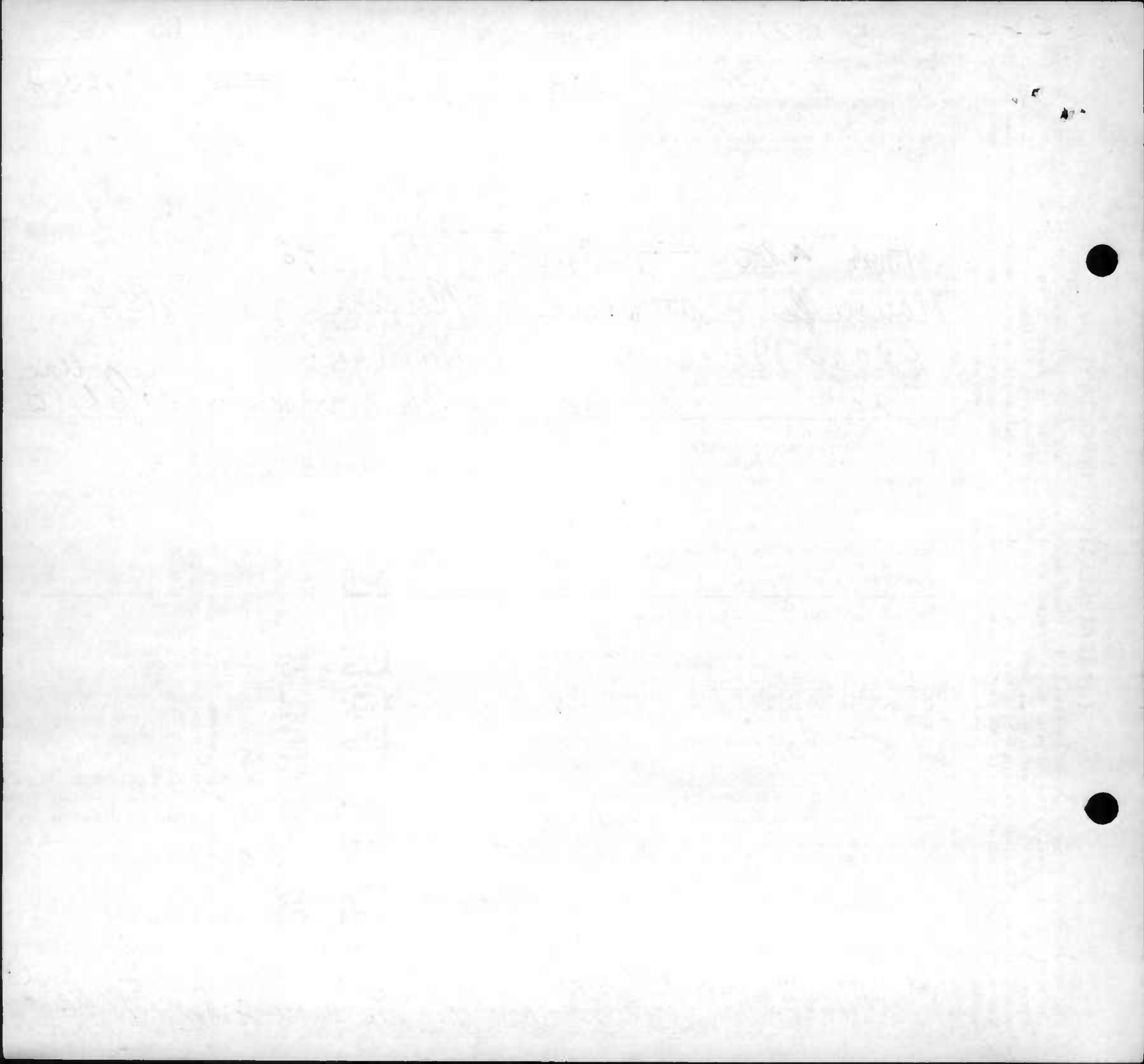
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 0526	
BIRTH NO. 65 0526		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Troney Joseph Thompson		2. DATE AND HOUR OF DEATH Jan. 16, 1965		1:15 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 235 S. East Avenue		A. STATE Maryland B. COUNTY 26-10			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 235 S. East Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 12, 1898	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Guilford Electronics		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Arthur Thompson			
14. MOTHER'S MAIDEN NAME Ida ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I			
16. SOCIAL SECURITY NO. 213-05-3384		17. INFORMANT Mrs. Catherine Thompson- 235 S. East Avenue			
18. 490.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION Instantaneous DUE TO (B) CORONARY THROMBOSIS Instantaneous DUE TO (C) CORONARY ARTERY DISEASE UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT 4 19 64 to 1/16 19 65 , that (I) (we) last saw the deceased alive on 1/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry J. Houska		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA		23D. ADDRESS 333 S. EAST AVE BALTO-24-MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR George A. Weber		ADDRESS 705 S. Ann St. #21231	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0527		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0527	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) NATHANSON-IDA			2. DATE AND HOUR OF DEATH 1/14/65 12:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 15-12		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI-HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3630 PARK HEIGHTS AVE #15		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED (specify) Widowed	8. DATE OF BIRTH 8/10/88	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Oscar Weiss			14. MOTHER'S MAIDEN NAME Hannah?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs Ida Robinson - 3630 Park Hts		
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) CAUSE OF DEATH (A) CARDIAC - ARREST - DUE TO (B) Complete Heart Block. DUE TO (C) HASCVD -			INTERVAL BETWEEN ONSET AND DEATH 2		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/13/65 19 to 1/14/65 19, that (I) (we) last saw the deceased alive on 1/14/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Any			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/14/65
23C. PHYSICIAN'S NAME (Type) ARON-ARY			23D. ADDRESS SINAI-HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 15/65		24C. NAME of CEMETERY or CREMATORY Hebrew Mt Carmel	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Levinson & Purkin 6018 Reisterstown Road			



FUNERAL DIRECTOR: IMPORTANT

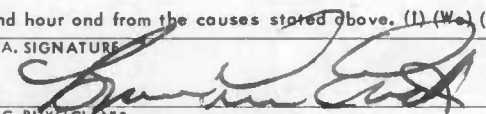
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0528	
BIRTH NO. 65 0528				CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) LENA LERNER		
2. DATE AND HOUR OF DEATH 1-14-65 4.10 p.m.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-13			5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 LEVINDALE Aged Home Belvedere + Greenspring		
6. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			7. STREET ADDRESS (If rural, give location) 32603 ROSEWOOD AVENUE		
8. DATE OF BIRTH - - - 1880			9. AGE (In years last birthday) 84		
10. SEX FEMALE			11. RACE WHITE		
12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED			13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
14. KIND OF BUSINESS OR INDUSTRY AT HOME			15. BIRTHPLACE (State or foreign country) (Russia)		
16. CITIZEN OF WHAT COUNTRY? USA			17. FATHER'S NAME LAZER WINTER		
18. MOTHER'S MAIDEN NAME Mollie ?			19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
20. SOCIAL SECURITY NO. -			21. INFORMANT Daughter Rose SCHNYDMAN		
22. ADDRESS 4002 GLENGYLE Ave			23. CAUSE OF DEATH		
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.11 CVA			25. INTERVAL BETWEEN ONSET AND DEATH 5 days		
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			27. YEARS Years		
28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
29. DATE OF OPERATION 0		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? (Yes or No) No	
32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		33. DATE OF OPERATION 4-1-1958 to 1-14-1965			
34. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		35. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		36. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
37. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		38. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		39. HOW DID INJURY OCCUR?	
40. I certify that (I) (this hospital) attended the deceased from 4-1-1958 to 1-14-1965 , that (I) (we) last saw the deceased alive on 1-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
41. SIGNATURE Jose Ardaiz				42. DATE SIGNED 1-14-65	
43. PHYSICIAN'S NAME (Type) Jose ARDAIZ				44. ADDRESS 2015 W. Rogers Ave, Baltimore 9	
45. BURIAL CREMATION, REMOVAL (Specify) BURIAL		46. DATE 1/15/65		47. NAME OF CEMETERY OR CREMATORY LUBOWITZ NUSI ARI	
48. LOCATION BALTIMORE		49. LOCATION MARYLAND			
50. DATE REC'D BY HEALTH DEPT. JAN 18 1965		51. NAME OF REGISTRAR Robert E. Fisher M.D.		52. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.	
53. ADDRESS 6010 REISTERSTOWN RD					

2004, 444.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0529	
BIRTH NO. 65 0529		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES LEON CARTER		2. DATE AND HOUR OF DEATH 1-10-65 930 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE CHARLES MARYLAND, ST. MARY'S C. CITY OR TOWN (If outside city limits, write RURAL and give township) GREAT MILLS D. STREET ADDRESS (If rural, give location) 68-00			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-25-19	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE CARTER				14. MOTHER'S MAIDEN NAME Hallie Luvonia Lincoln			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Alice Butler: Olney, Md.		ADDRESS	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Carcinomatosis DUE TO (B) Bronchial Cancer DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-5 1965 to 1-10 1965 . that (I) (we) last saw the deceased alive on 1-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-10-65	
23C. PHYSICIAN'S NAME (Type) BRUCE LEE EVATT				23D. ADDRESS M.D. JOHNS HOPKINS Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/15/64		24C. NAME of CEMETERY or CREMATORY Int Zion Cem.		24D. LOCATION (City, town, or county) (State) Int Zion, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR George R. Snowden		ADDRESS Rockville, Md.	

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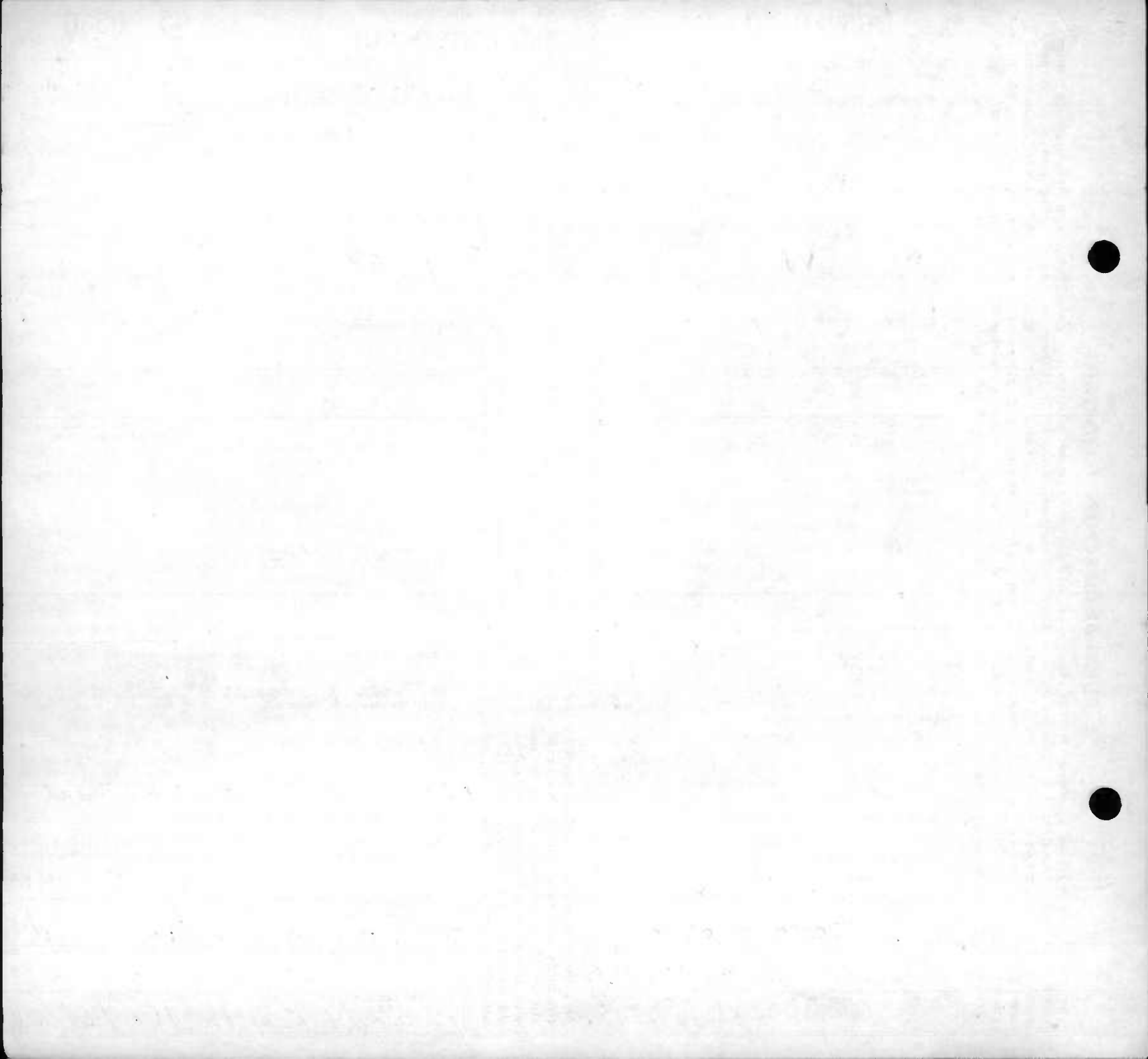
J. I. B. I.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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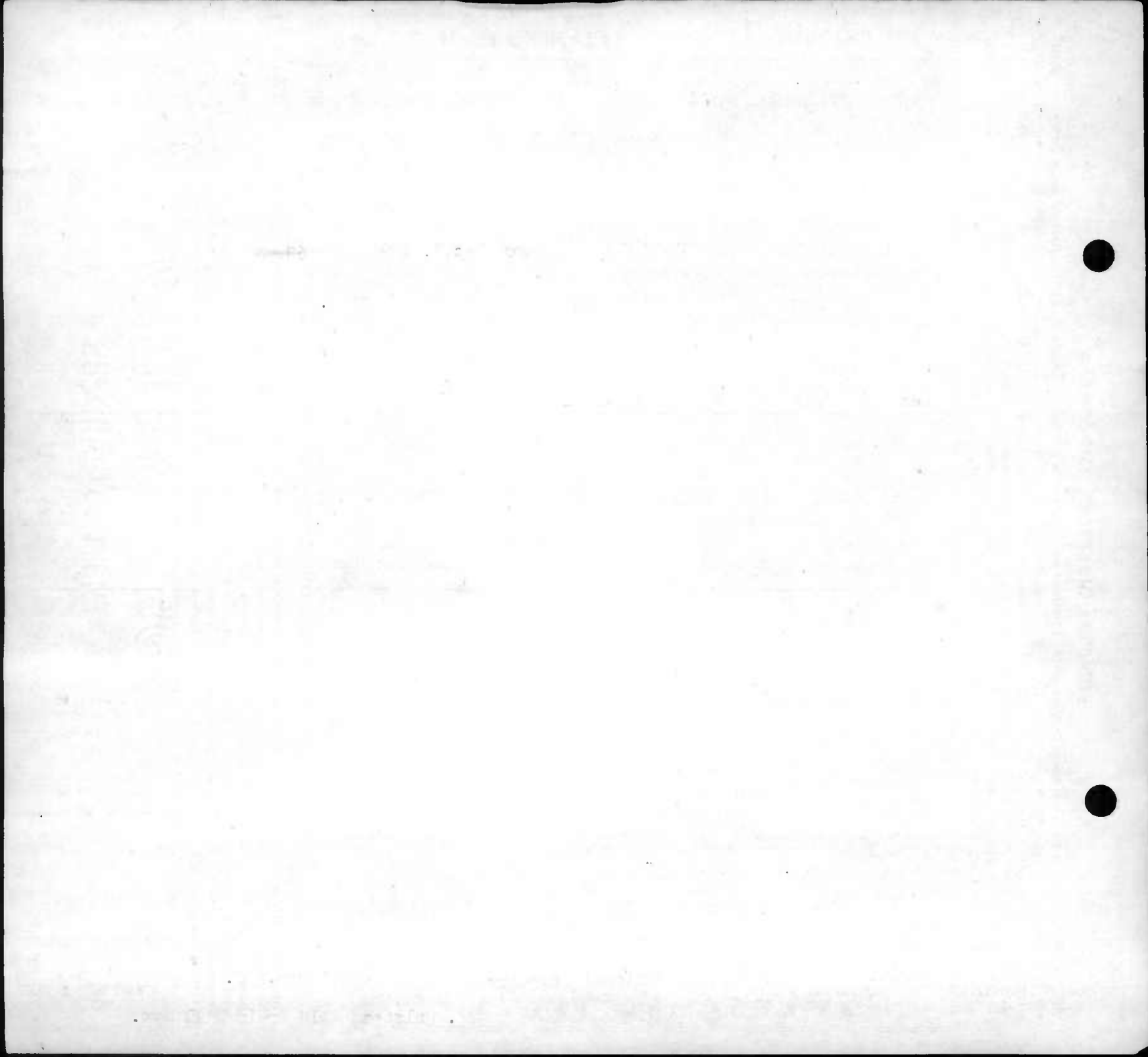
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0530 4	
BIRTH NO. 65-01159 0530				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Boy. Elliott		2. DATE AND HOUR OF DEATH January 12/65 4:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE (Parents) C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE (23) D. STREET ADDRESS (If rural, give location) 1326 W. LOMBARD ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH January 11, 1965	9. AGE (In years last birthday) 5	If Under 1 Yr. Months: Days: Hours: Min. 5 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Elliott			14. MOTHER'S MAIDEN NAME Madeline Messersmith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Hosp. RA/Reeds		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 762.51 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Massive Atherosclerosis DUE TO (B) Prematurity 5 mos. DUE TO (C) 2165. 1102.		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/12/65 19 65 to 1/12 19 65 , that (I) (we) last saw the deceased alive on 1/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Florino Francisco				23B. DATE SIGNED 1/12/64	
23C. PHYSICIAN'S NAME (Type) Florino Francisco				23D. ADDRESS Bon Secours Hospital Balto 23 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/13/65		24C. NAME OF CEMETERY OR CREMATORY St Peter's	
24D. LOCATION Balt Md		24E. LOCATION (City, town, or county) (State) 23			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR ADDRESS Thomas J. Kenny Inc 1600 Heller	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						BIRTH NO. 65 0531		CERTIFICATE OF DEATH		Registered No. 65 0531	
1. NAME OF DECEASED (Type or Print) FLEETWOOD, JOSEPH GEORGE						2. DATE AND HOUR OF DEATH 1 15 65 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 39						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1115 Myrtle Avenue					
5. SEX male		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH Dec 3, 1896		9. AGE (In years last birthday) 68		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME unknown						14. MOTHER'S MAIDEN NAME unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. WWI 215-18-9045		17. INFORMANT wife Mrs Lillian Fleetwood			ADDRESS		
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardiovascular Disease						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 15 Hrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5:05pm 1 15 65 to 1 15 65 that (I) (we) last saw the deceased alive on 1 15 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Harris Semarine, M.D.</i> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Harris Semarine MD						23D. ADDRESS Provident Hospital M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965				25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR A. Halstead			ADDRESS 918 Druid Hill Ave.		



FUNERAL DIRECTOR: IMPORTANT

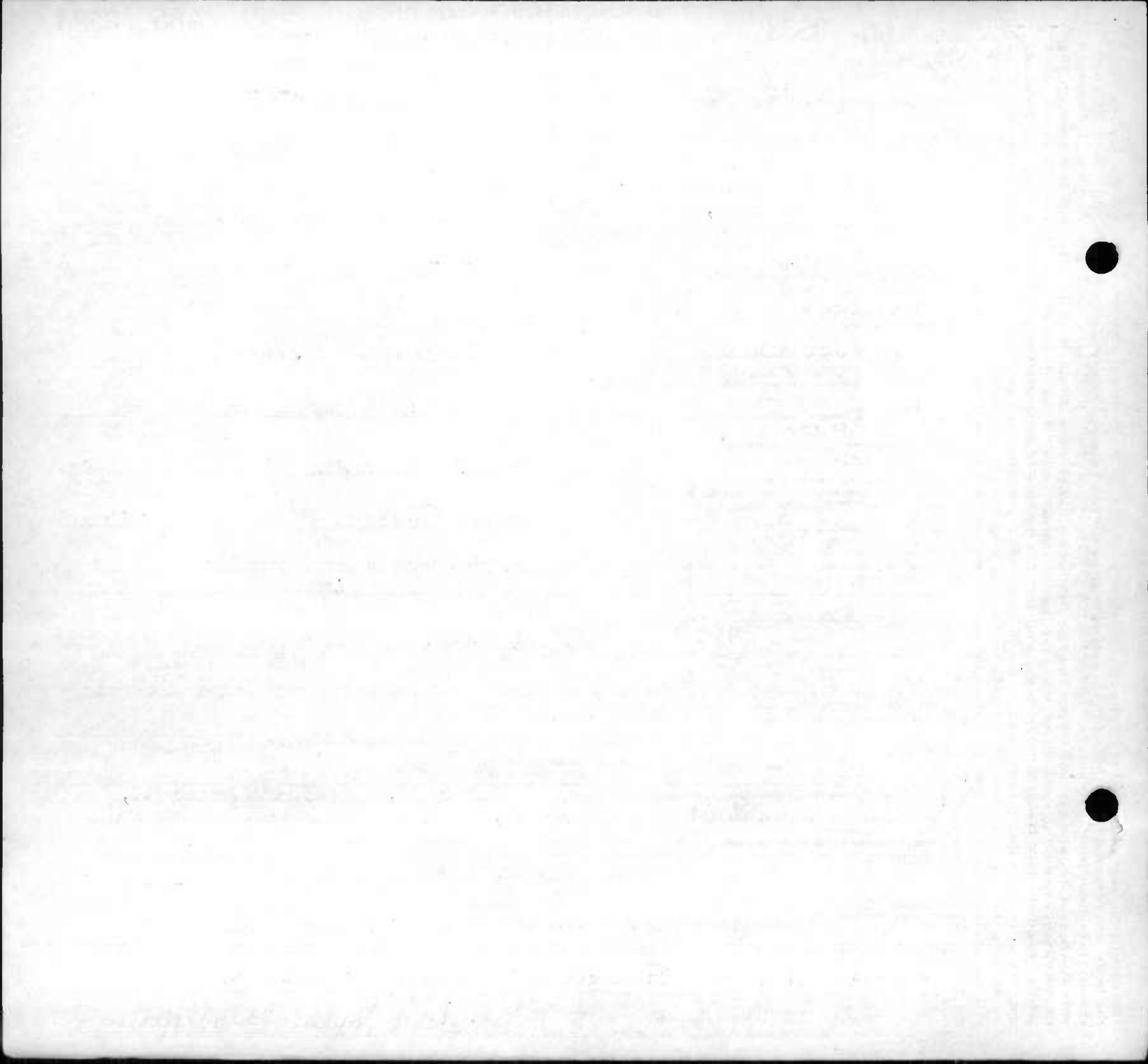
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0532					CERTIFICATE OF DEATH					Registered No. 65 0532				
M.E. CASE NO.										2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>ANDREW WITTIG</i>										1-12-65				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
HOSPITAL OR INSTITUTION										A. STATE B. COUNTY				
826 N. LINWOOD AVE.										MARYLAND 7-01				
5. SEX										6. RACE				
M										W				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)										8. DATE OF BIRTH				
SINGLE										12-1-1895				
9. AGE (In years last birthday)										69				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10B. KIND OF BUSINESS OR INDUSTRY				
WAREHOUSE CLERK										BRASS & COPPER CO.				
11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?				
MARYLAND										U.S.A.				
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME				
ANDREW WITTIG										HELENE RIEMER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.				
YES										W.W.I.				
17. INFORMANT										ADDRESS				
Miss Helene Wittig										826 N. Linwood Ave.				
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										ARTERIOSCL. C.V. DIS.				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										2-3 years				
ANTECEDENT CAUSES														
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
0										NO				
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
NO														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)										21E. INJURY OCCURRED				
(APPROX.)										While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from 1959 to 1/12/65										that (I) (we) last saw the deceased alive on 1/11/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE										23B. DATE SIGNED				
Benj. B. Moses, M.D.										1/13/65				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS				
BENJ. B. MOSES, M.D.										448 N. LUZERNE AVE. BALTO. 28, MD				
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE				
BURIAL										1-16-65				
24C. NAME OF CEMETERY or CREMATORY										24D. LOCATION (City, town, or county) (State)				
OAK LAWN CEMETERY										BALTO., MD.				
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR				
JAN 18 1965										Robert E. Farley, M.D.				
25C. FUNERAL DIRECTOR										ADDRESS				
Farley Miller										2334 Jefferson St.				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0533		CERTIFICATE OF DEATH		65 0533	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Myrtle Emkey		2. DATE AND HOUR OF DEATH 1-17-65 4:10 pm.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY 26-08			
		C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3717 East Lombard Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-24-94	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME SAMUEL WILSON			14. MOTHER'S MAIDEN NAME ELIZABETH SCHAEFFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 420.141 260X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Myocardial Infarction DUE TO		5 minutes	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Coronary Thrombosis DUE TO		5 minutes	
		(C) Arteriosclerotic Cardiovascular Disease			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 16, 1965 to January 17, 1965 , that (I) (we) last saw the deceased alive on January 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Cooke		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-17-65	
23C. PHYSICIAN'S NAME (Type) Robert Cooke		23D. ADDRESS 4940 Eastern Avenue 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-20-64		24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH CEM.	
24D. LOCATION (City, town, or county) (State) BALTO., Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Hester, Miller, 2334 Jefferson St.	



IS: 42-60-60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0534

BIRTH NO. 65 0534

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Lillian ~~Guthermuth~~ GUTERMUTH

2. DATE AND HOUR OF DEATH

January 14, 1965 8:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE CORRECTED 1-25-65

NAME OF HOSPITAL OR INSTITUTION

Baltimore City Hosptials
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Rural

D. STREET ADDRESS (If rural, give location)

201 S. Taylor Avenue 21221

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

4-16-1905

9. AGE (In years
last birthday)

59

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Bodenbure

14. MOTHER'S MAIDEN NAME

Mary Maier

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

410X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Rheumatic Heart Disease
DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

46 Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Probable Myocardial Infarction
Rule out Pulmonary Embolus

Several Hours

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED
While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 14, 19 65 to January 14, 19 65, that (I) (we) last saw the deceased alive on January 14, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Howard K. Rathbun

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

January 14, 1965

23C. PHYSICIAN'S NAME (Type)

Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-18-1965

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Co.

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lassala Funeral Home 7401 Release Road

ADDRESS

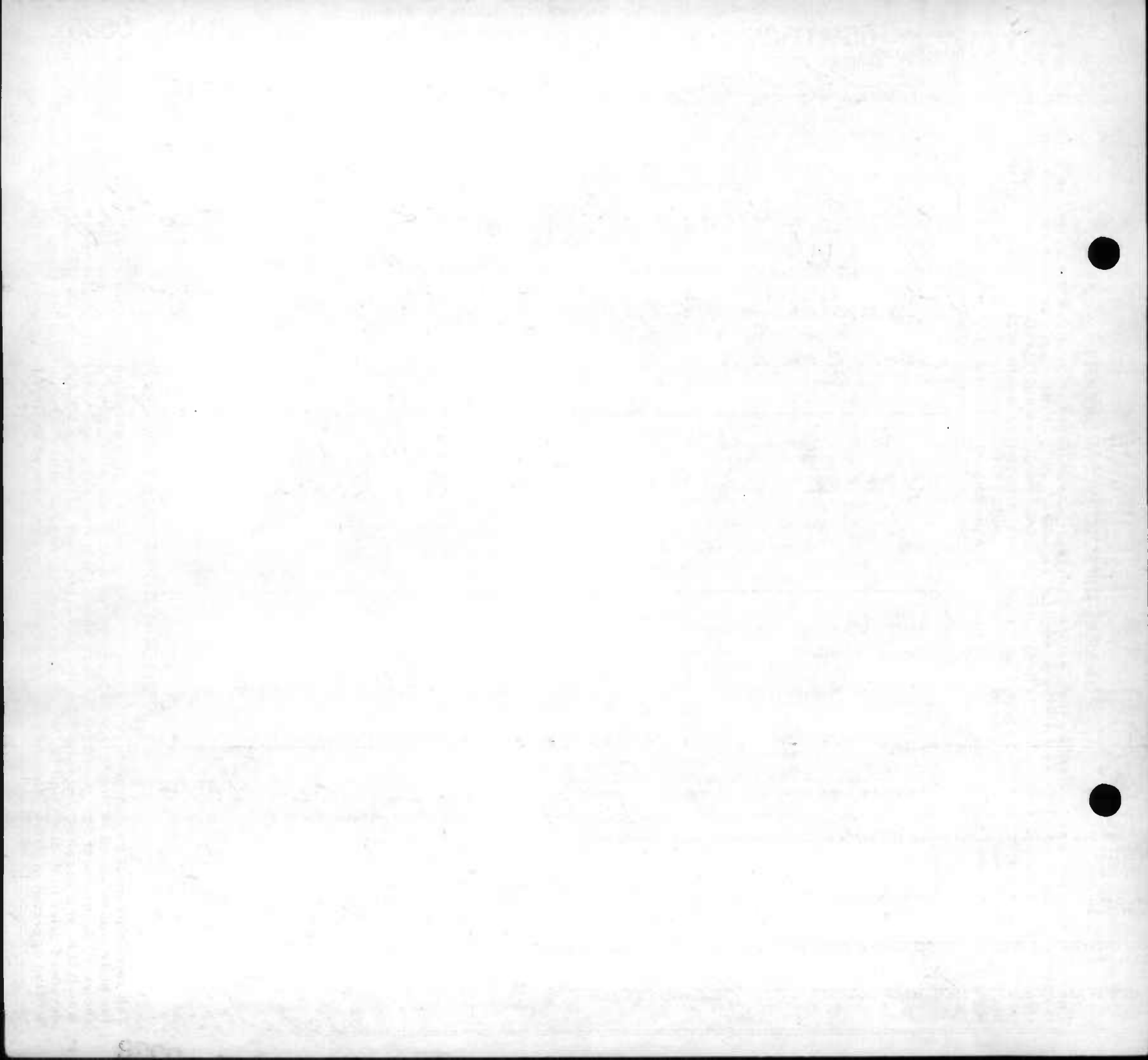
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 0535					
BIRTH NO. 65 0535										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <i>Christopher Hiesing</i>					2. DATE AND HOUR OF DEATH <i>January 13 1965</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Balto.</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1006 Wildwood Pkwy.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>					
D. STREET ADDRESS (If rural, give location) <i>1006 Wildwood Pkwy.</i>										
5. SEX <i>M.</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>W.</i>	8. DATE OF BIRTH <i>Jan. 30, 1882</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoemaker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Shoe repairing</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>216-32-7426</i>		17. INFORMANT <i>Boyer F. Klein</i>			ADDRESS <i>Balto 39</i>		
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardiovascular Disease</i>					INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 13</i> 19 <i>65</i> to <i>Jan 13</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>Jan 13</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour one from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Louis T. Lavy</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>Jan 14 - 1965</i>		
23C. PHYSICIAN'S NAME (Type) <i>LOUIS T. LAVY M.D.</i>					23D. ADDRESS <i>1844 W. North Ave Baltimore 17 Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-16-1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i>			24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>			25C. FUNERAL DIRECTOR <i>Living Byers</i>			ADDRESS <i>8728 Hittory Road.</i>	



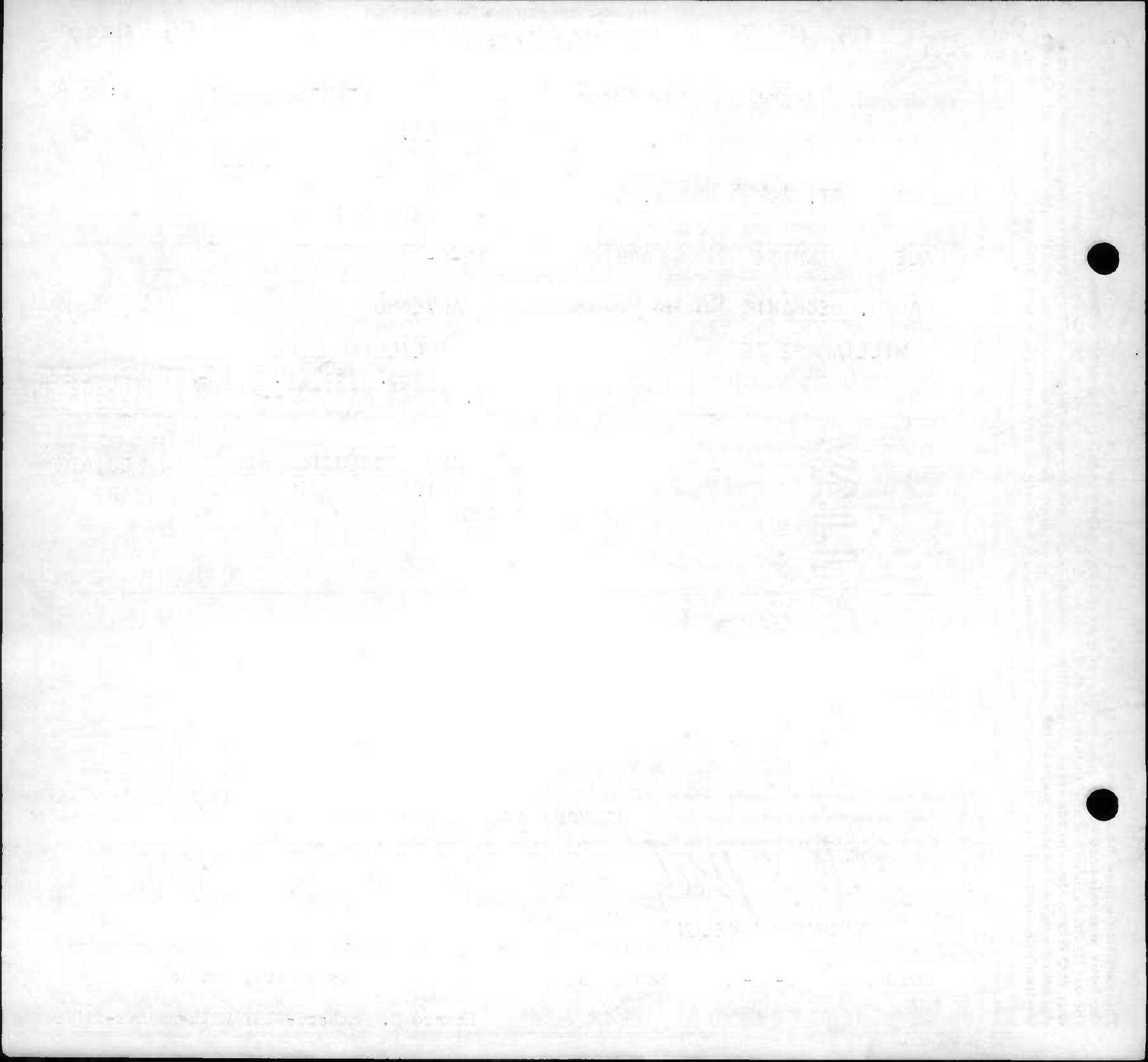
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0536		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0536	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Florence S. Mahon		2. DATE AND HOUR OF DEATH 10:20 PM Jan 12, 1965 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 6-03			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 211 N. Chester St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH 3-7-77	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Simon Fink (Dec)		14. MOTHER'S MAIDEN NAME Barbara Ambrein			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-4126		17. INFORMANT ADDRESS AGNES MAHON 211 N. CHESTER ST.	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage 12-29-65 to 1-12-65		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1st 1965 to Jan. 12, 1965 . that (I) we last saw the deceased alive on Jan 12, 1965 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.					
23A. SIGNATURE Youngsik Moon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan 12, 1965	
23C. PHYSICIAN'S NAME (Type) YOUNGSIK MOON		23D. ADDRESS Maryland Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-16-65	24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS John M. Weber & Sons Inc 401 S. Chester St	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H. 5201

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 0537	
BIRTH NO. 65 0537				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HENZE, CARROLL EDWIN			2. DATE AND HOUR OF DEATH 1-15-65 3:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 D. STREET ADDRESS (If rural, give location) 510 WESTGATE ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-5-99	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO. MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY G. W. Anderson	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME WILLIAM HENZE			14. MOTHER'S MAIDEN NAME LILLIAN BODE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215104828	17. INFORMANT Mrs. Hattie M. Henze-510 Westgate Rd ST. AGNES RECORDS--CATON & WILKENS AVES		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CORONARY OCCLUSION WITH INFARCTION (B) ASCVD (C) _____ INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YEARS					
18. II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 2 19 65 to JANUARY 15 19 65 , that (I) (we) last saw the deceased alive on JANUARY 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard J Kelly M.D.				23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) RICHARD J KELLY M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave-21229	



1
D-300

BALTIMORE CITY HEALTH DEPARTMENT

65 0538
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0538

BIRTH NO.		M.E. CASE NO. 59335		1. NAME OF DECEASED (Type or Print) DENNIS C. DEATH		2. DATE AND HOUR PRONOUNCED DEAD January 16, 1965 5:15 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-17 D. STREET ADDRESS (If rural, give location) 5109 Chalgrove Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH July 11, 1920	9. AGE (In years last birthday) 44	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morgan R. Death				14. MOTHER'S MAIDEN NAME Betty Radcliff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes W # 2		16. SOCIAL SECURITY NO. 189-09-0288		17. INFORMANT ADDRESS Mrs. Betty Death, 5109 Chalgrove Ave.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty cirrhosis of the liver (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-17-65 EXAMINER'S NAME (Type) Rudiger Breitenecker ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/20/65		23C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		23D. LOCATION (City, town, or county) (State) Elkridge, Howard Co., Md. ✓	
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR R. Vernon Lemon ADDRESS 5611 Park Heights Ave.			

WALL
CORNER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0539

BIRTH NO. 65 0539

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Hyman SHILOVITZKY

2. DATE AND HOUR OF DEATH

1-15-65

3.25 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

LEVINDALE HEBREW HOME + INFIRMARY

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Bald Md

B. COUNTY

27-17

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

BELVEDERE at GREENSPRING (LEVINDALE NURSING HOME)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

1-1-1869

9. AGE (In years)

(last birthday) 96

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

EUROPE (Russia)

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NO

17. INFORMANT

Levindale Nursing Home & Infirmary (Belvedere at Greenspring)

ADDRESS

18.

527.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Bronchopneumonia

DUE TO

4 days

(B) Pulmonary Emphysema +

DUE TO

Fibrosis.

Years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Generalized Arteriosclerosis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-2-1939 to 1-15-1965.

that (I) (we) last saw the deceased alive on 1-15-1965 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jose Ardaiz

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-15-65

23C. PHYSICIAN'S NAME (Type)

JOSE ARDAIZ

23D. ADDRESS

2015 W. Rogers Ave. Baltimore 9, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/18/65

24C. NAME OF CEMETERY or CREMATORY

Beth JACOB (Uecair)

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

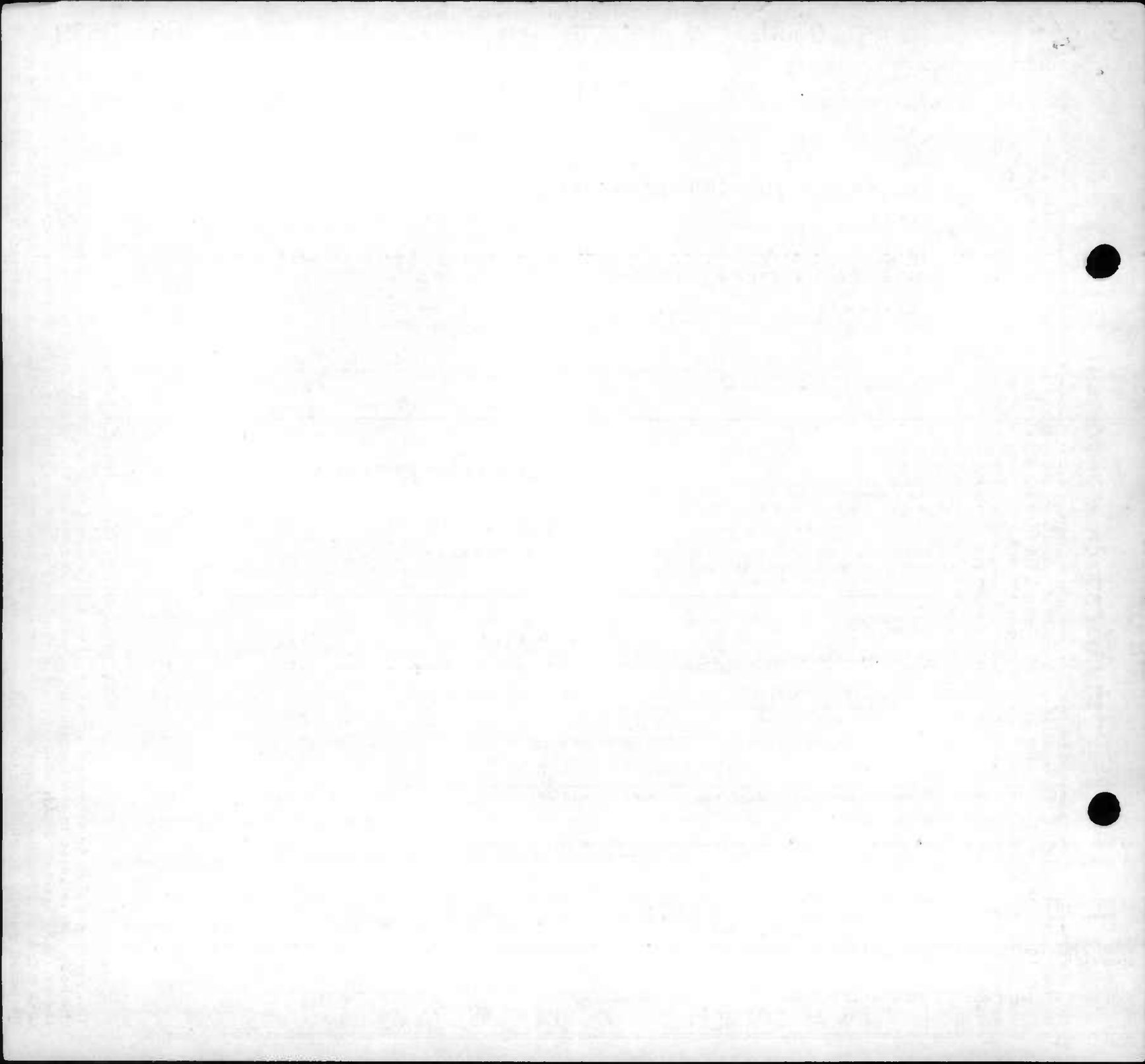
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Sol Levinson & Bros Inc. 6010 Reisterstown Rd.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0540	
BIRTH NO. 65 0540		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Dawson		2. DATE AND HOUR OF DEATH 1/13/65 9:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Virginia			
CERTIFICATE CORRECTED 1-21-65		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Kilmarnock			
South Balto. Gen. Hosp.		D. STREET ADDRESS (If rural, give location) Rt. 1, Kilmarnock, Virginia			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 6/13/1885	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Steptor Dawson		14. MOTHER'S MAIDEN NAME Marie Davis- Anna Tyler		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louis Whittaker ADDRESS	
18. 420.1 I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Plurial fibrillation			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		DUE TO myocardial ischemia			
ANTECEDENT CAUSES		(B) Acute Appendicitis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO Acute Cholecystitis			
		(C) Cholelithiasis			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1/13/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that XX (this hospital) attended the deceased from Jan 13 1965 to Jan 13 1965 , that (X) (we) last saw the deceased alive on Jan 13 1965 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chung K. Bae M.D.				23B. DATE SIGNED 1/13/65	
23C. PHYSICIAN'S NAME (Type) CHUNG K. BAE, M.D.				23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Lebanon Baptist Church - Lively, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John C. Mitchell & Sons, Inc. Balto.	
				ADDRESS Kilmarnock VA.	

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65 0541

BALTIMORE CITY HEALTH DEPARTMENT

65 0541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Kaja

(Kaga) Pedersen

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 4, 1965

9:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

S.S. Javara - at sea

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Svenberg, Denmark

3-02 V-61

D. STREET ADDRESS (If rural, give location)

Willemoesuet 10

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11-27-22

9. AGE (In years last birthday)

42

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Svendborg Denmark

12. CITIZEN OF WHAT COUNTRY?

Denmark

13. FATHER'S NAME

Jorgen Jorgensens

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Leo Pederson- Svenberg Denmark

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of barbiturate DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

ship

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

at sea aboard S.S. Javara

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

Jan. 4 1965

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

apparently ingested overdose barbiturate

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 16, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Svendborg-Denmark

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John C. Miller Inc. - 6415 Belair Rd

VALLEY FORGE

BY CONTENT

Page 2

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

HERBERT E.

HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

January 13, 1965

8:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3829 Hickory Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan 4, 1887

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George W. Harris.

14. MOTHER'S MAIDEN NAME

Caroline Hoover.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth H. Baker. 3829 Hickory Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
1/14/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/16/65

23C. NAME OF CEMETERY or CREMATORY

St. Mary's, Hampden

23D. LOCATION

(City, town, or county)

(State)

3900 Roland Ave, Balto, Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Austin E. Donovan 3818 Roland Ave

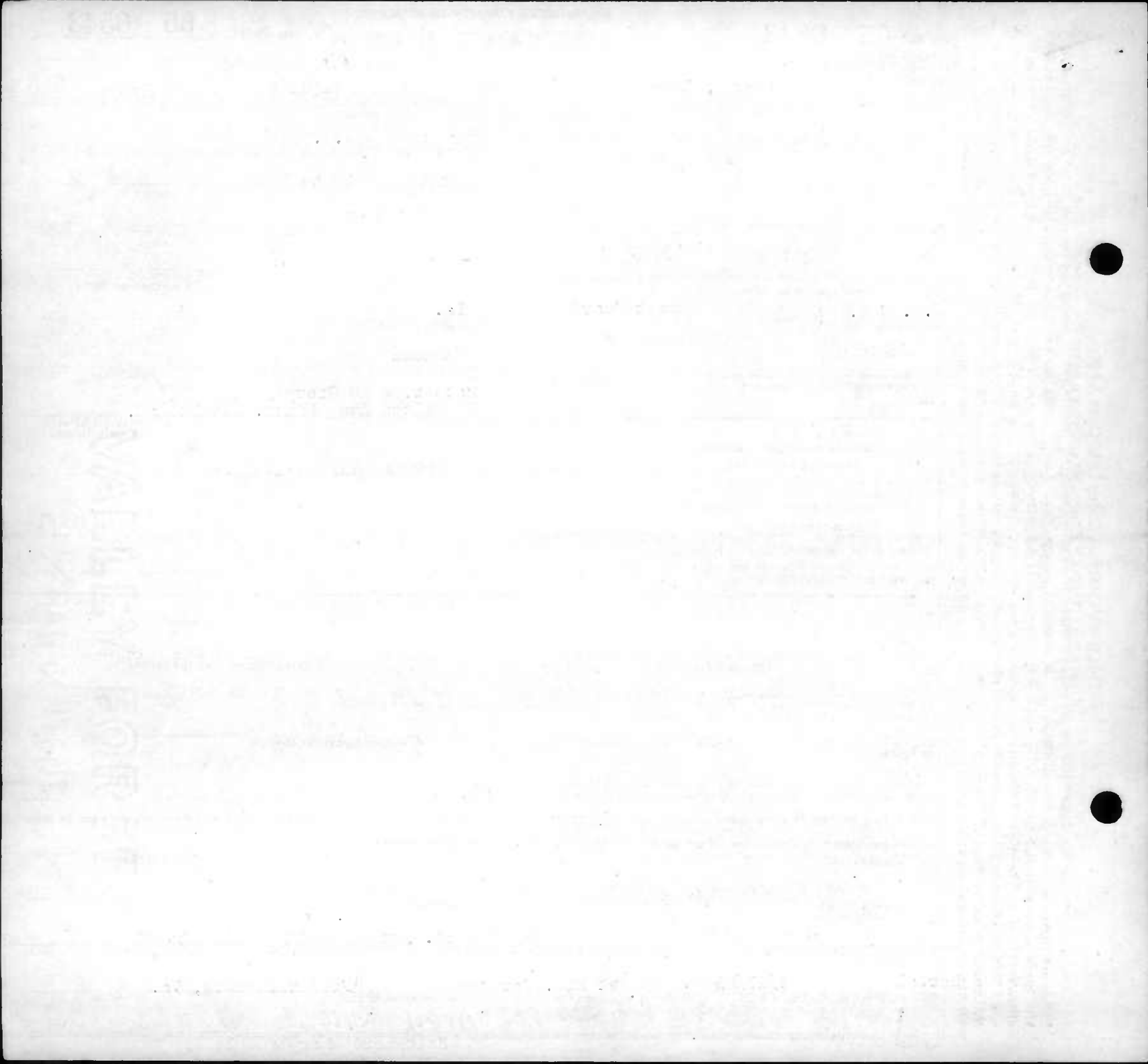
ADDRESS

VALLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0543	
BIRTH NO. 65 0543				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) McGrory, John			2. DATE AND HOUR OF DEATH 1-14-65 2:49a M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL EMERGENCY ROOM			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Linthicum Heights D. STREET ADDRESS (If rural, give location) 36 Milton Avenue 52-00		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-15-29	9. AGE (In years last birthday) 35	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Gov.		10B. KIND OF BUSINESS OR INDUSTRY Coast Guard		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Katherine MC Grory 36 Milton Ave Linth. Heights Md.		
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Massive Myocardial Infarction DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 14 19 65 January 14 19 65 , that (I) (we) last saw the deceased alive on January 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl Matthey				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Carl Matthey				23D. ADDRESS St. Agnes Hospital Balto 29	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/65		24C. NAME OF CEMETERY or CREMATORY Sunset Mem. Gardens	
24D. LOCATION Fredericksburg, Va.		24E. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
24F. NAME OF REGISTRAR Robert E. Jarboe		24G. FUNERAL DIRECTOR ADDRESS H. H. Hubbard 4107 WILKENS AVE Baltimore Maryland 21229			



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

RUDOLPH (Rudolf) GREINER, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

January 14, 1965

8:52 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2019 Old Frederick Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1/13/05

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CABINET MAKER

10B. KIND OF BUSINESS OR INDUSTRY

JOHNS HOPKINS LAB.

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.
213094654

17. INFORMANT

ADDRESS

ELIZABETH GREINER 2019 OLD FREDERICK RD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1/18/65

23C. NAME OF CEMETERY or CREMATORY

MEADOWRIDGE CEM.

23D. LOCATION

(City, town, or county)

(State)

HOWARD CO., MD.

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD 4107 WILKENS AVE. 21229

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0545	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0545					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) HELEN S. Gittings		2. DATE AND HOUR OF DEATH 1-14-65 9:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN Hosp. of Md.		A. STATE MD. 8. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2130 West North Ave.			
5. SEX Female	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-26-14	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME — Randolph Miller		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-24-8518		17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 578 XT 260 X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) MASSIVE GASTROINTESTINAL HEMORRHAGE DUE TO			
		(B) CAUSE NOT DETERMINED DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		① MYOCARDIAL INFARCTION - ACUTE ② DIABETES ACIDOSIS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12-65 to 1-14-65 , that (I) (we) last saw the deceased alive on 1-14-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Renato R. Espina M.D.				23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) Renato R. Espina				23D. ADDRESS LUTHERAN HOSP. OF MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.			

USA

CHART

MASSIVE GAS IN INJECTION
HORIZONTAL
CAUSE NOT DETERMINED

(1) MAGNIFICENT INJECTION - ADULT
(2) DIRECTOR - ADULT

NO

LEONARD R. ESPINO
LEONARD R. ESPINO

1-14

1-12

1-12

1-14

1
H525

65 0546

BALTIMORE CITY HEALTH DEPARTMENT

65 0546

BIRTH NO.

M.E. CASE NO. 59329

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE E. HENSON			2. DATE AND HOUR PRONOUNCED DEAD January 15, 1965 11:18 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CERTIFICATE CORRECTED 2/10/65 PROVIDENT HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2517 Salem Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 18, 1902	9. AGE (In years last birthday) 62	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Menyon Kelly			ADDRESS 5618 Wesley Ave.		
18. 443 X 7 E 936.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Hypertensive heart disease, pulmonary emphysema and chronic cor pulmonale DUE TO (B) DUE TO (C) Cerebral contusions with convulsive disorder (post-traumatic epilepsy)		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Brunt & Bloom Streets	
21D. TIME OF INJURY (APPROX.) Found 10 4 64		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Undetermined - fell on street or was hit by automobile	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John E. Adams EXAMINER'S NAME (Type) John E. Adams, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify) Burial			23B. DATE 1-19-65		23C. NAME OF CEMETERY or CREMATORY Not known
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR George J. Kline
24D. LOCATION (City, town, or county) Baltimore, Md			(State) Md		

Birth Cert. of deceased. 2/10/65 cpb

STANDARD FORM NO. 100-10

VALLEY FORGE

THIS CERTIFICATE

IS A

7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 0547	
BIRTH NO. 65 0547		M.E. CASE NO. 65 0547			
1. NAME OF DECEASED (Type or Print) REBECCA H. ROSS			2. DATE AND HOUR OF DEATH 1/16/65 12:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1902 POPLAR GROVE ST.		
5. SEX 7.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 3-7-02	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Charles Harris		14. MOTHER'S MAIDEN NAME Ellen Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-303078		17. INFORMANT CHART Otes Harris ADDRESS 4028 Eliza ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) ACUTE MYOCARDIAL INFARCTION (B) (C) INTERVAL BETWEEN ONSET AND DEATH —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSIVE CARDIOVASCULAR DISEASE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-9 1965 to 1-16 1965 , that (I) (we) last saw the deceased alive on 1-16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Reneas A. Espina				23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA				23D. ADDRESS M.D. LUTHERAN HOSPITAL OF MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore MD.		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Talbot	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Morris			

100-4-1-1

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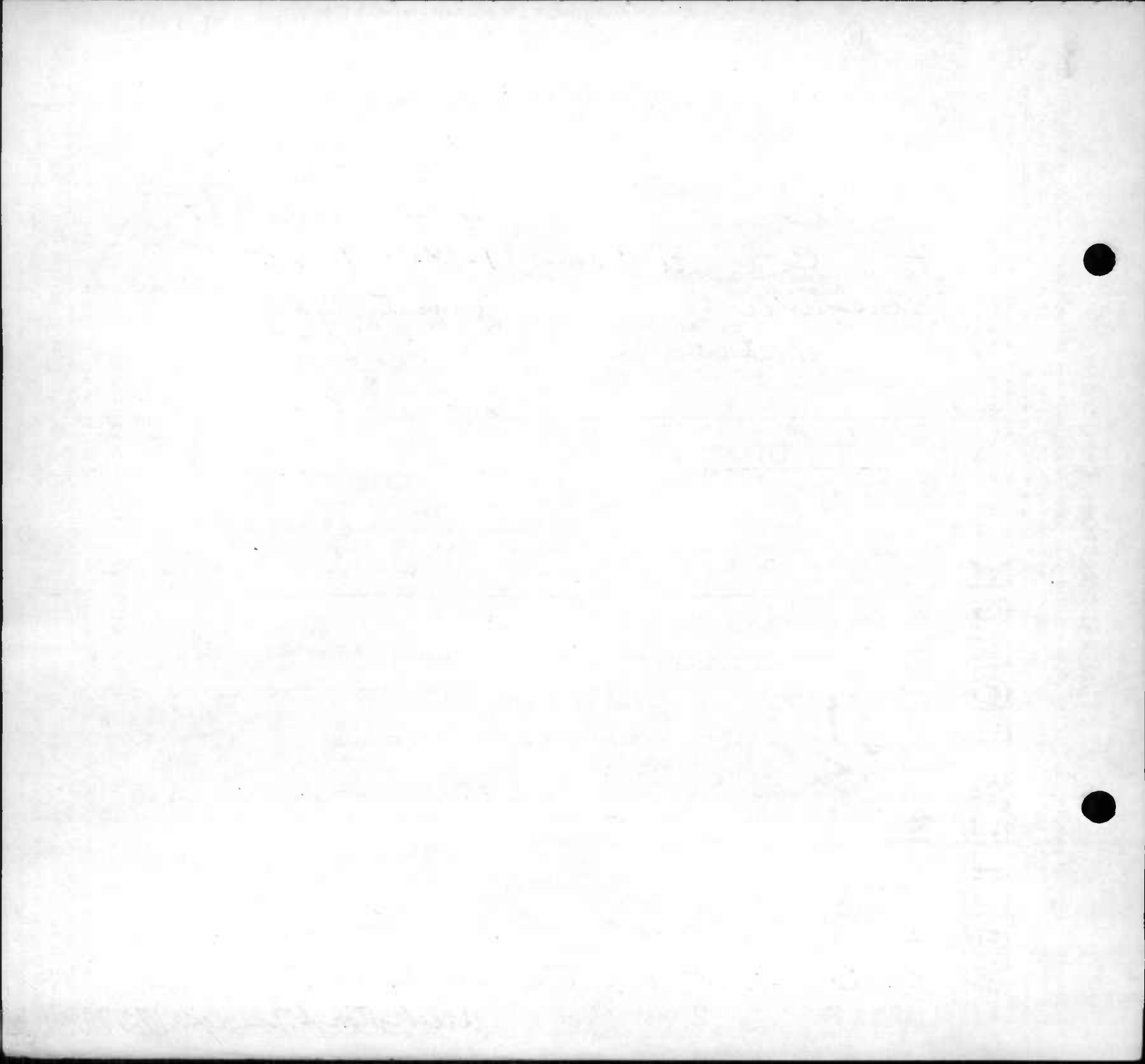
100-4-1-1

100-4-1-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance at the deceased prior to death); and (6) No physician was in regular attendance at the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0548	
BIRTH NO. 65 0548				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alice Lewis Johnson		January 12 th 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
404 Gold St.		Baltimore, Md.		Maryland 14-03	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				404 Gold St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
7	C	Widow	1-18-1899	65	Housewife
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Augusta, Georgia					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Alice Lewis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				James Johnson Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
159X I		Malignancy, metastatic		3 months	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		GI tract malignancy	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-25-64 to 1-12-65 that (I) (we) last saw the deceased alive on 1-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Luis F Gonzalez				1-15-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Luis F Gonzalez		University Hospital BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-16-65		Arbutus Mem. Pk.	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1965		Robert E. Farley, M.D.		Washington Phillips 1722 N. Monroe St.	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY B. MOORING

2. DATE AND HOUR PRONOUNCED DEAD

January 14, 1965

5:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4228 Colborne Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4228 Colborne Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

April 16, 1892

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greenville, N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Abraham Barnhill

14. MOTHER'S MAIDEN NAME

Ann Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Essie Collins

ADDRESS

Same

18. 4221 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-15-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

State

Removal 1-15-65

Greenville

N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 18 1965

Robert E. Finken, M.D.

Arbington A. Phillips 1727 N. Mount St.

RECEIVED

TO THE HONORABLE
SPEAKER OF THE HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

FROM THE
COMMISSIONER OF THE GENERAL LAND OFFICE

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the land in the State of Texas, and to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
Your obedient servant,
[Signature]Commissioner of the General Land Office

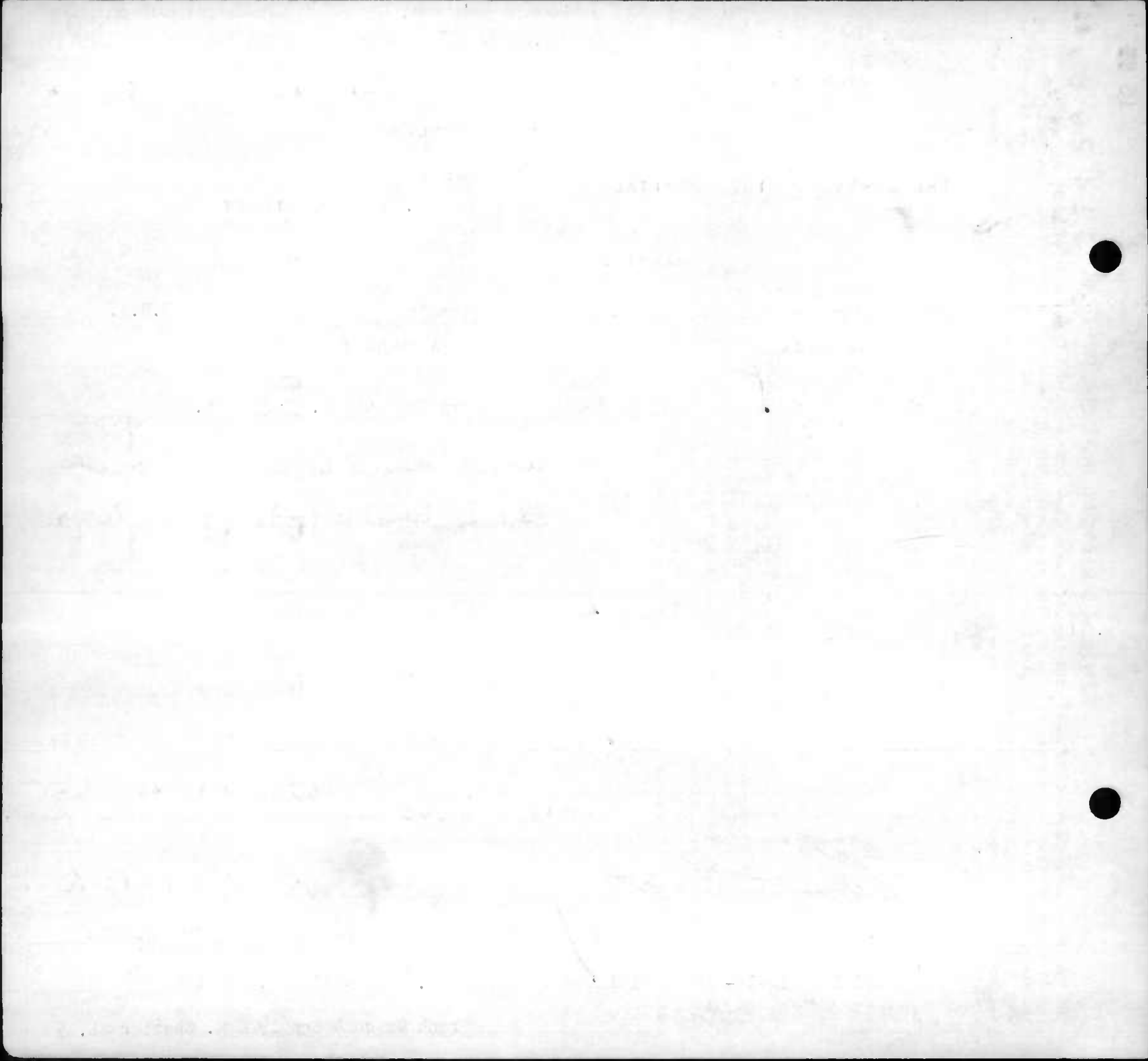
Enclosed for the
Honorable Speaker of the House of Representatives
is a copy of the report of the
Commissioner of the General Land Office
dated the 10th inst. in relation to the
land in the State of Texas.

Very respectfully,
Your obedient servant,
[Signature]
Commissioner of the General Land Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

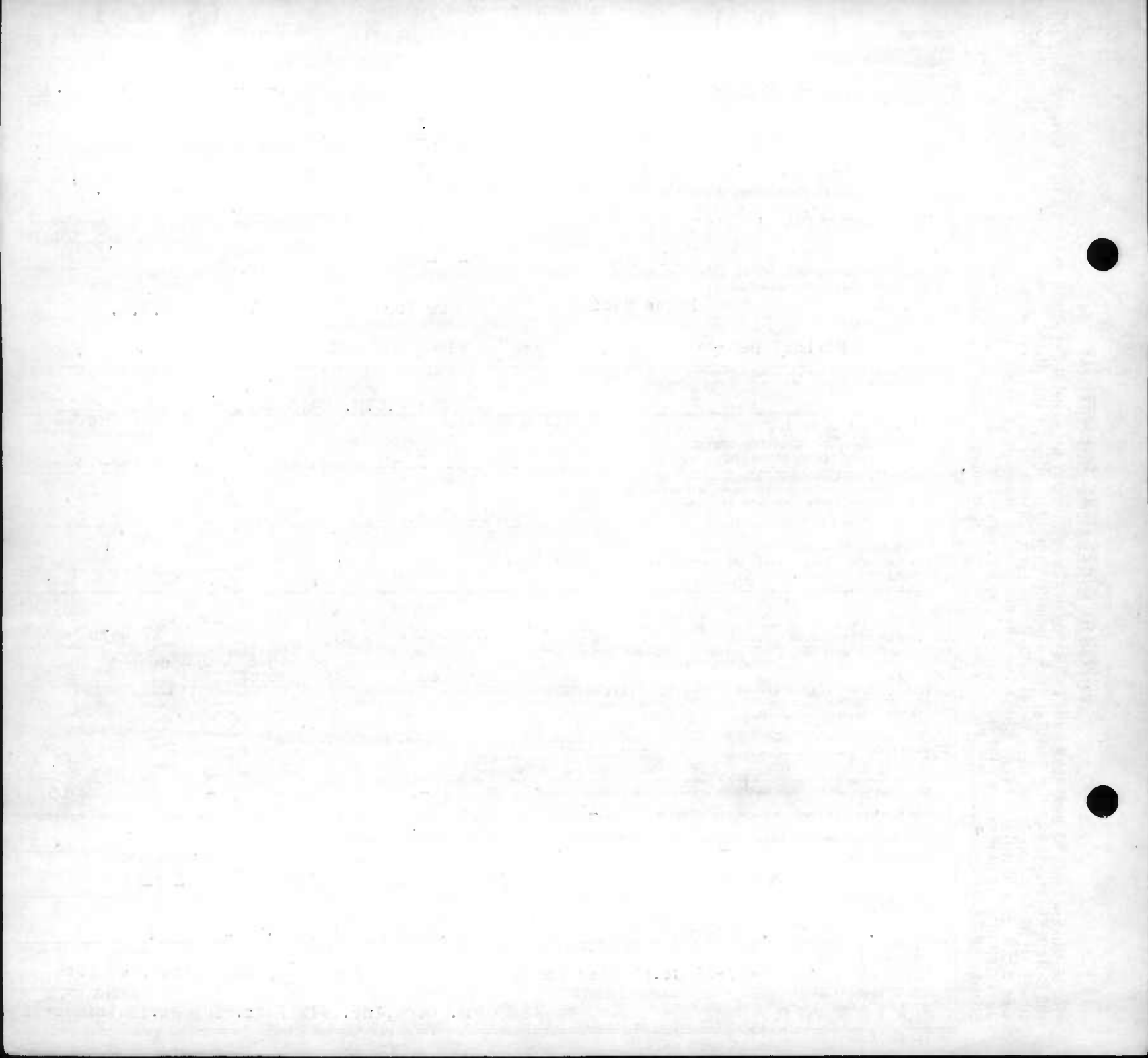
BIRTH NO. 65 0550		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0550	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) JOHN ZACK			1-15-65 10 ³⁰ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY 7-04		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 941 N. CHAPEL STREET		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/14/90	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Strple Jack			11. BIRTHPLACE (State or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANK ZACK			14. MOTHER'S MAIDEN NAME ANNA HANDRE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) World 1 World 1 217 07 8682 82			16. SOCIAL SECURITY NO. 217 07 8682 82		
			17. INFORMANT Mary Zak 941 N. Chaple St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute bronchitis			CAUSE OF DEATH (A) DUE TO Acute bronchitis (B) DUE TO Chronic bronchitis & pulmonary em 30 yrs. (C)		
INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-10-65 to 1-15-65 , that (I) (we) last saw the deceased alive on 1-15-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Lee Evans M.D.				23B. DATE SIGNED 1-15-65	
23C. PHYSICIAN'S NAME (Type) BRUCE LEE EVANS M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Frank Cvach & Son 900 N. Chester St. 5	



FUNERAL DIRECTOR: IMPORTANT

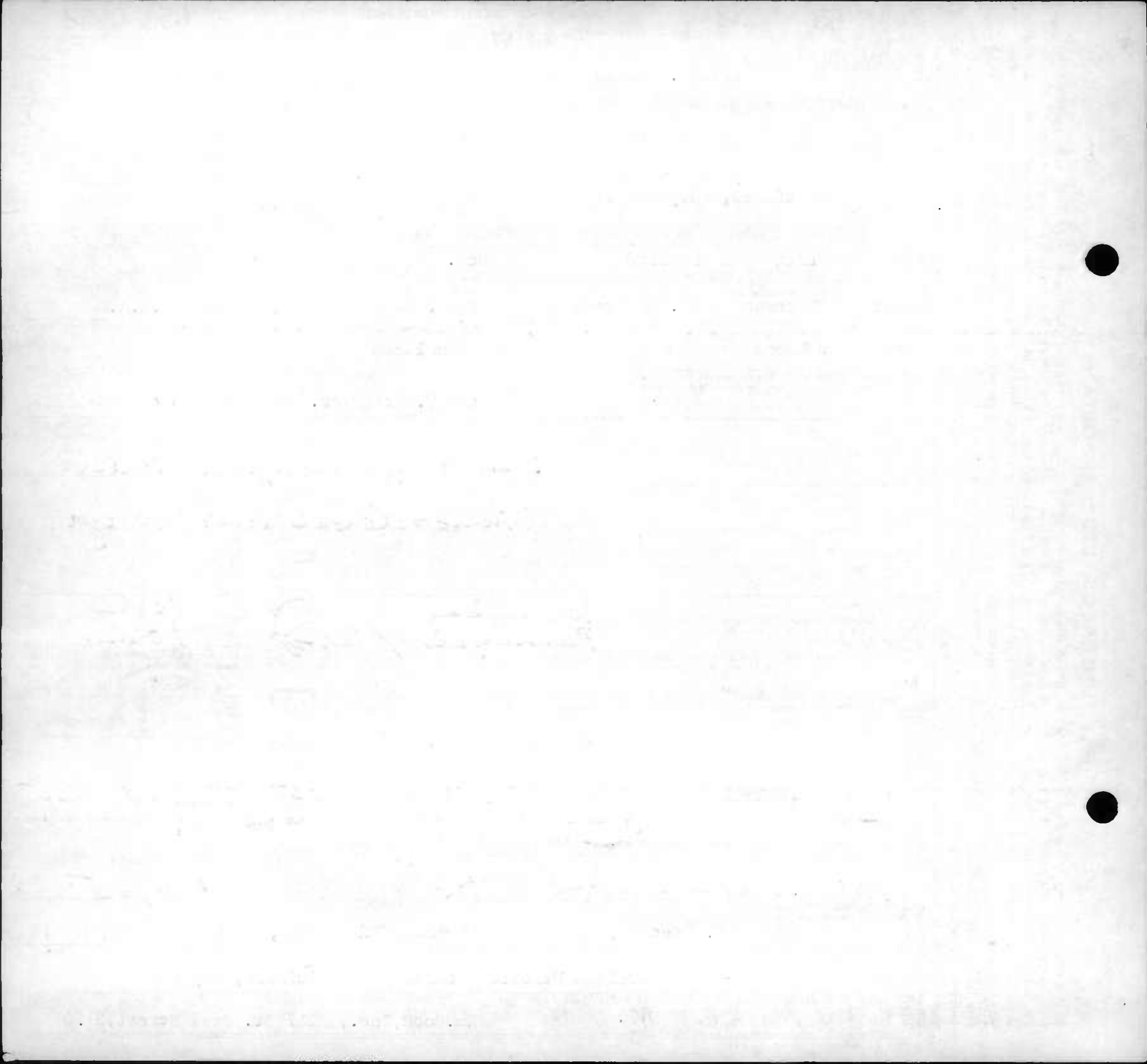
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0551</u>	
BIRTH NO. <u>65 0551</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>1-15-65</u> <u>11:45</u> A. M.			
1. NAME OF DECEASED (Type or Print) <u>Edward De Mayo</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-05</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3102 Reisterstown Road #21215</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>3-15-02</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Groom</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Horse Racing</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael DeMayo</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Valentine</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>RECORDS: B.C.H. 4940 Eastern Avenue #21224</u>			
18. <u>4-20-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Bilateral Cardiovascular</u> DUE TO <u>Accident</u> (B) <u>Arteriosclerosis</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Myocardial Infarction</u>		17 Days			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> 19 <u>64</u> to <u>1-15</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. Rathbun</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-15-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Howard K. Rathbun</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue #21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24B. DATE <u>1-17-65</u>	24C. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pine Lawn, Long Island, New York</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Fildner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Gook, Inc., 1217 St. Paul St., Baltimore 2</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 0552		CERTIFICATE OF DEATH		65 0552	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jesse T. Marler, Sr		January 15, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
2733 Maryland Avenue Baltimore, Maryland 21218		Maryland		12-06	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 21218			
		D. STREET ADDRESS (If rural, give location)			
		2733 Maryland Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
male	white	married	Dec. 24, 1882	82	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
retired Foreman		Pa. Railroad		North Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		unknown		unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Jess T. Marler, Jr., 2612 Crabapple Road-21234	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Dissecting aneurysm DUE TO		10 da.	
		(B) Arteriosclerosis, severe DUE TO		10 yrs.	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Uremia Paralysis of legs		10 da. 10 da.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Nov 14 19 55 to Jan 15 19 65; that (I) (we) last saw the deceased alive on Jan 11 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Norman R. Freeman, Jr				1/18/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		11 West 29th Street, Baltimore 21218, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1-19-65		Moreland Memorial Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1965		Robert E. Freeman		Wm. Cook, Inc., 1217 St. Paul Street, 21202	



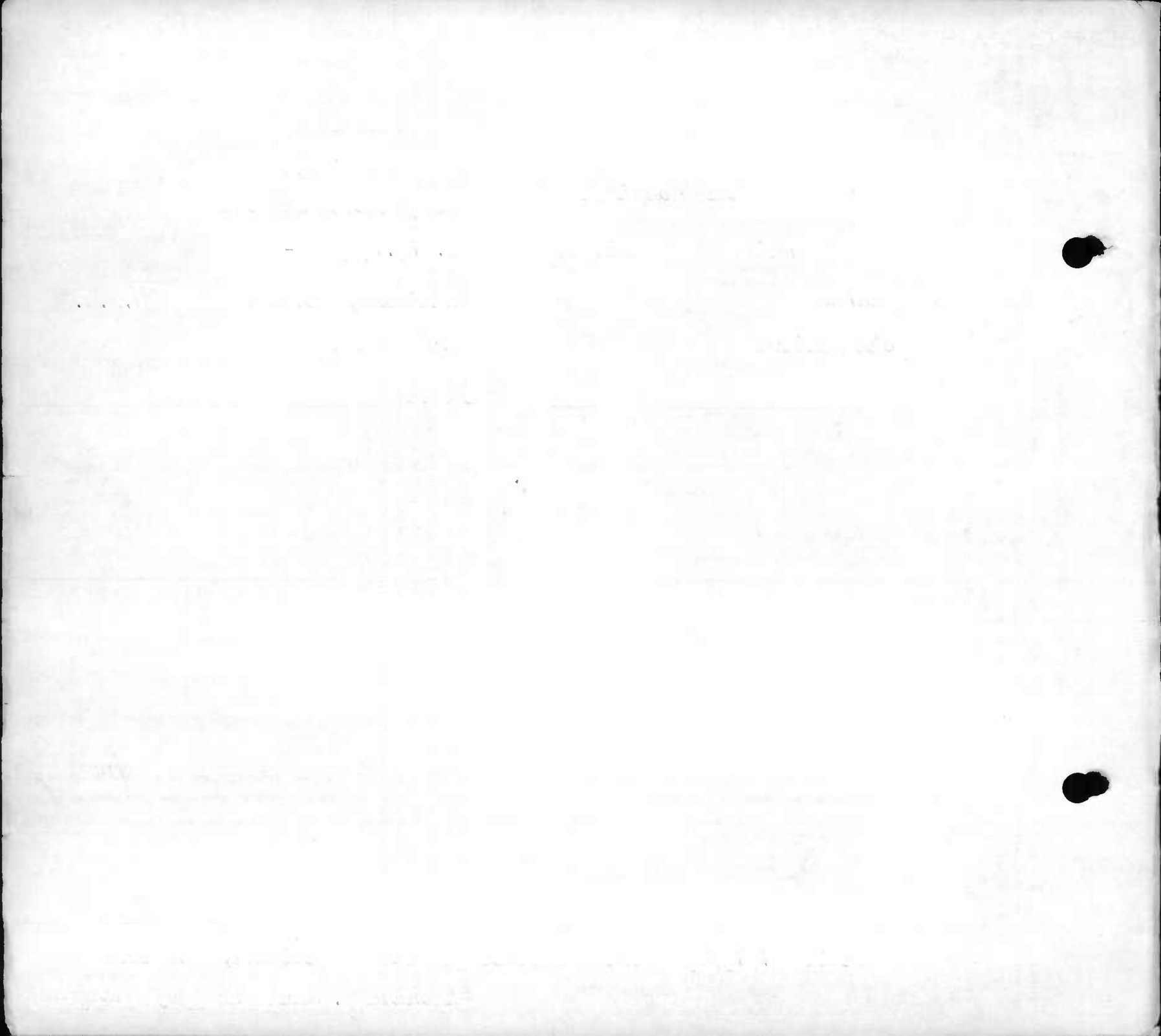
5-100

37

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

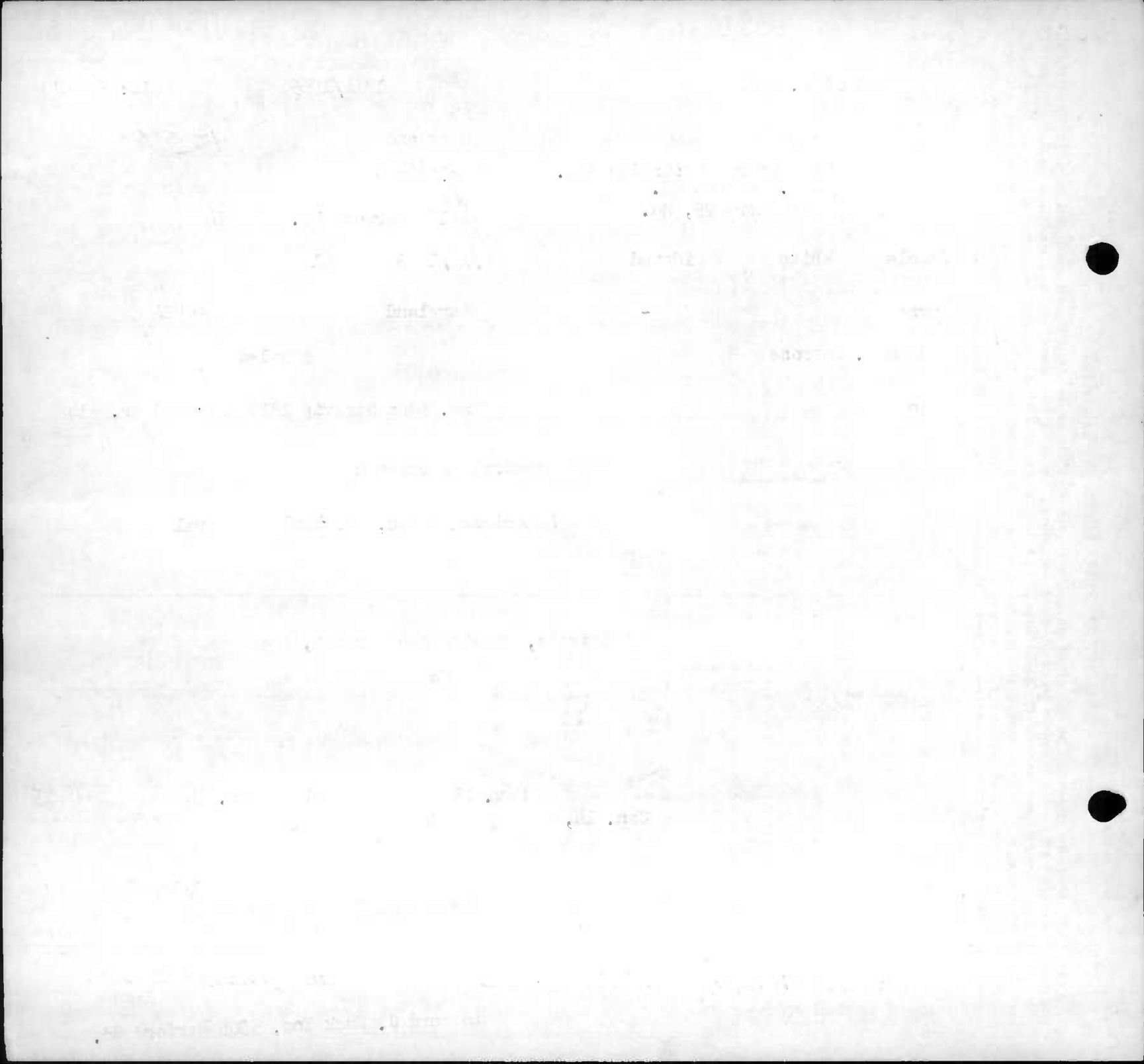
BIRTH NO. 65 01731 65 0553		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0553 4	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Schieve		2. DATE AND HOUR OF DEATH 1-14-65 1:10P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balts C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8045 Stratman Road			
5. SEX ?	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH Jan. 14. 1965	9. AGE (In years last birthday) -	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Schieve			14. MOTHER'S MAIDEN NAME Marie Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Father		
			ADDRESS Same		
18. 759.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory Failure DUE TO (B) CNS Immaturity DUE TO (C) Frusory 13-13		INTERVAL BETWEEN ONSET AND DEATH 5 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/14 19 65 to 1/14 19 65. that (I) (we) last saw the deceased alive on 1/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Willard E. Stuebel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/15/65	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Jankovitch		25C. FUNERAL DIRECTOR Leonard J. Ruek Inc 5305 Harford Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

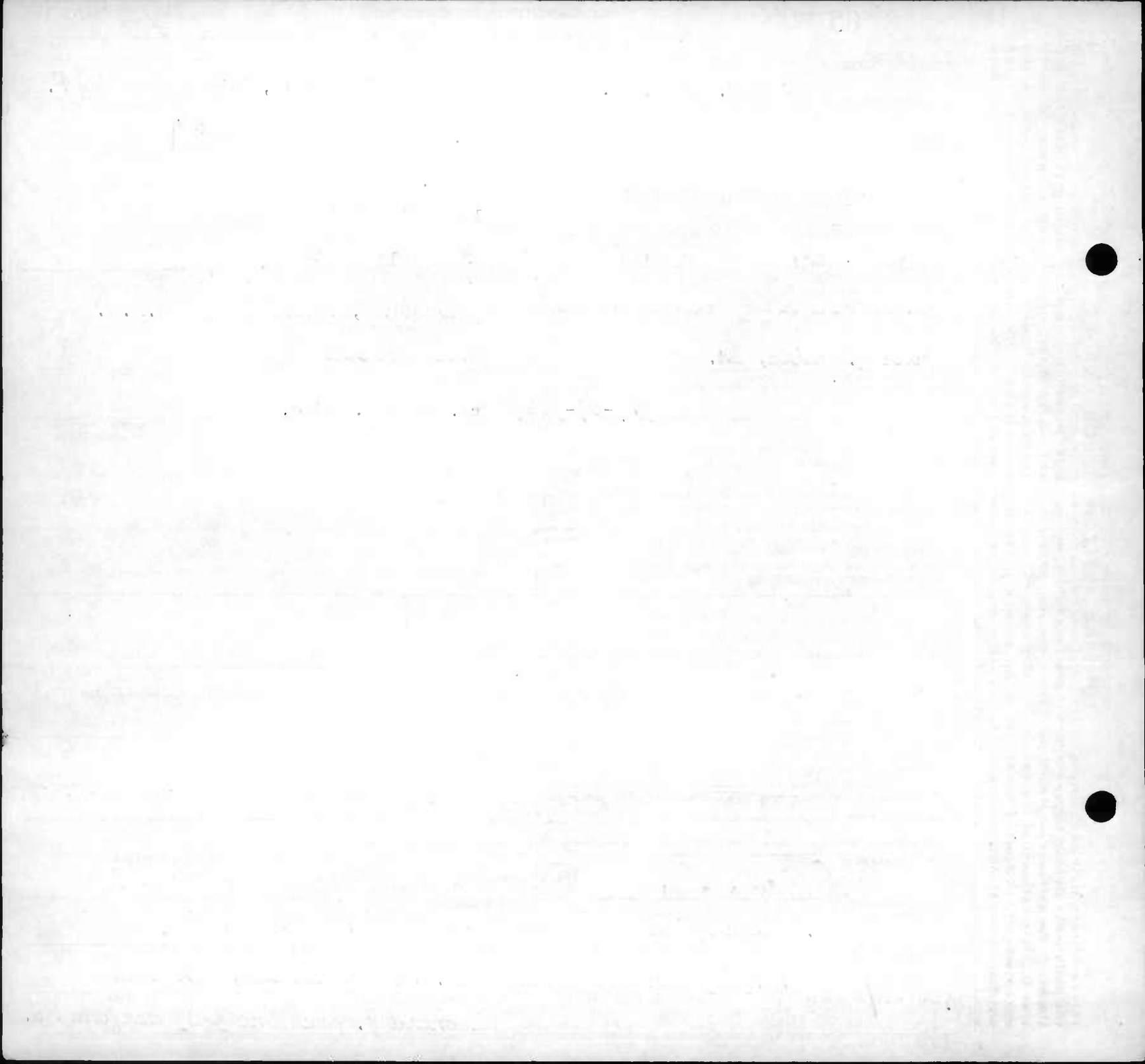
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0554					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 0554				
1. NAME OF DECEASED (Type or Print) LYDIA A. ROSS					2. DATE AND HOUR OF DEATH 1/14/1965 12:45 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
The Gundry Sanitarium Inc. 2 N. Wichham Rd. Baltimore 29, Md.					Maryland		27-38		
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					1818 Sherwood Dr. #14				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Female	White	Widowed		9/15/1883	81				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Nurse				-		Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John T. Ambrose					Knowles				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						Mrs. Edna Strevig 1818 Sherwood Dr. #14			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) Cerebral Hemorrhage				
ANTECEDENT CAUSES					(B) Arteriosclerosis, Cerebral & General				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Arthritis, Carcinoma of Breast, Age				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Nov. 25 19 61 to Jan. 14 19 65, that (I) (we) last saw the deceased alive on Jan. 14, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Robert E. Farley</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/14/65		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS The Gundry Sanitarium Inc. 2 N. Wichham Rd. Baltimore 29				
M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1/18/65		Trinity Cemetery		Long Green, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
JAN 18 1965		Robert E. Farley M.D.		Leonard J. Ruck Inc., 5305 Harford Rd.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 0555	
CERTIFICATE OF DEATH				Registered No. _____	
BIRTH NO. M.E. CASE NO.		2. DATE AND HOUR OF DEATH JANUARY 12, 1965 6 P. M.			
1. NAME OF DECEASED (Type or Print) JOHN E. WAITE, JR.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 27-09			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 1647 KINGSWAY ROAD			
5. SEX male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/18/1915	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Foreman		10B. KIND OF BUSINESS OR INDUSTRY Eastern Stainless		11. BIRTHPLACE (State or foreign country) Canonsburg, Penna	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John E. Waite, Sr.			
14. MOTHER'S MAIDEN NAME Maude Roberts		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 319-09-3684		17. INFORMANT Mrs. Adele M. Waite,		ADDRESS Same	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Jan 12 1965 to Jan 12 1965 , that (1) (we) lost sight of the deceased alive on Jan 12 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE A. Allan Spier		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type) A. Allan Spier		23D. ADDRESS M.D. 1501 Parkridge Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/15/65		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Pk	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc	
ADDRESS 5305 Harford Rd.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 0556	
CERTIFICATE OF DEATH				Registered No. 65 0556	
BIRTH NO. 65 0556					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ila L. Weber		Jan. 13, 1965.		11 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<div style="border: 1px solid black; padding: 2px;"> CERTIFICATE CORRECTED 1-21-65 </div> (If not in hospital or institution, give street address or location) Union Memorial Hospital		A. STATE Md. B. COUNTY 27-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3031 Northern Parkway			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Apr. 28, 1895	9. AGE (In years last birthday) 70 69	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Dagwell		14. MOTHER'S MAIDEN NAME Maude Selleck			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. S. Allen Weber		ADDRESS same
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 Days	
<div style="border: 1px solid black; padding: 5px;"> MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None 21C. WHERE DID INJURY OCCUR? None 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) None 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? None 22. I certify that (I) (this hospital) attended the deceased from Jan 9th 1965 to Jan 13 1965, that (I) (we) last saw the deceased alive on Jan 9th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE L. L. GORDY M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED Jan 14 - 65 23C. PHYSICIAN'S NAME (Type) L. L. GORDY 23D. ADDRESS M.D. 5106 Hayford Rd Baltimore Md 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/16/65 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965 25B. NAME OF REGISTRAR Robert E. Johnson 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14, Md. </div>					

V.S. 153

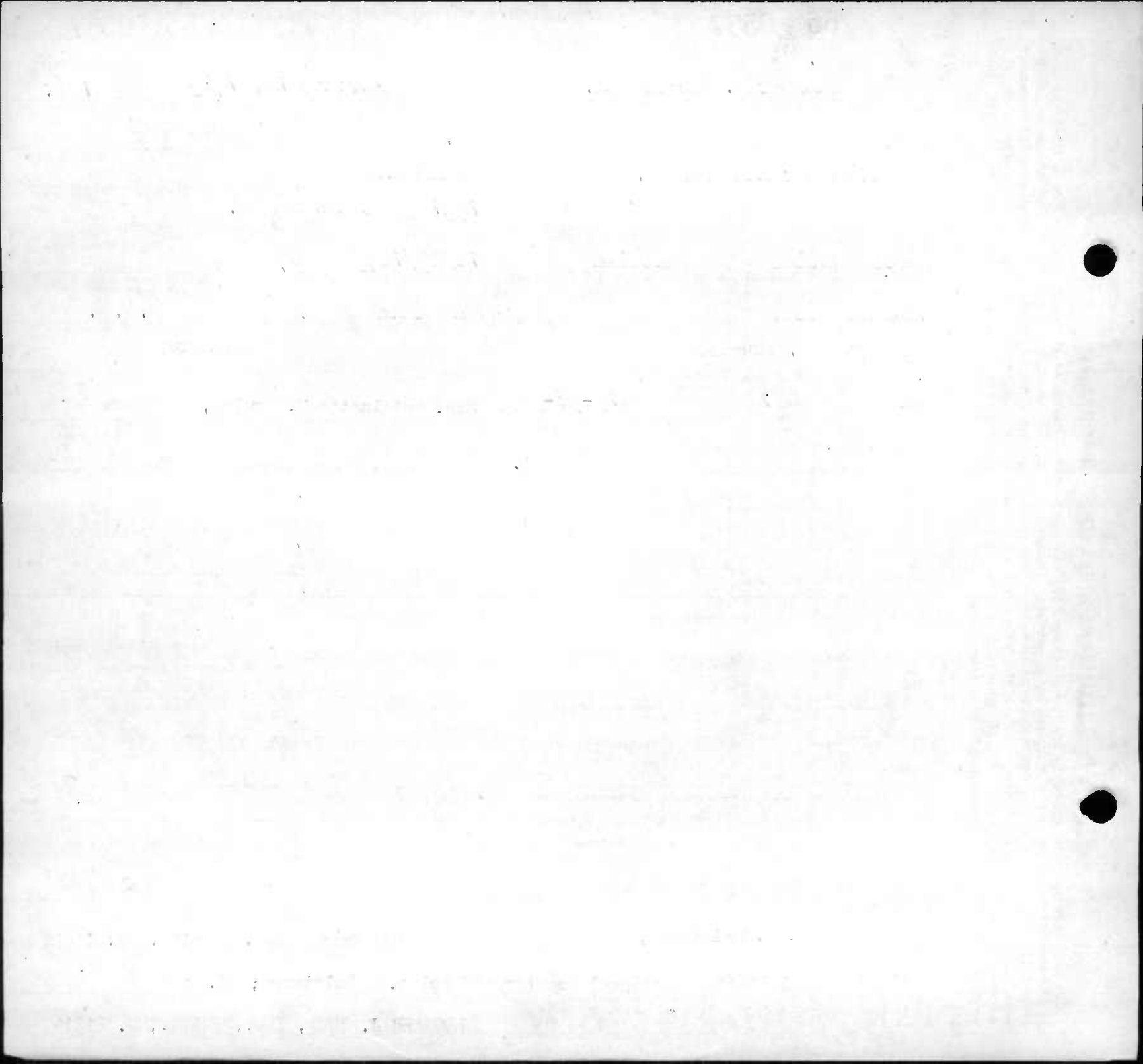
1-21-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

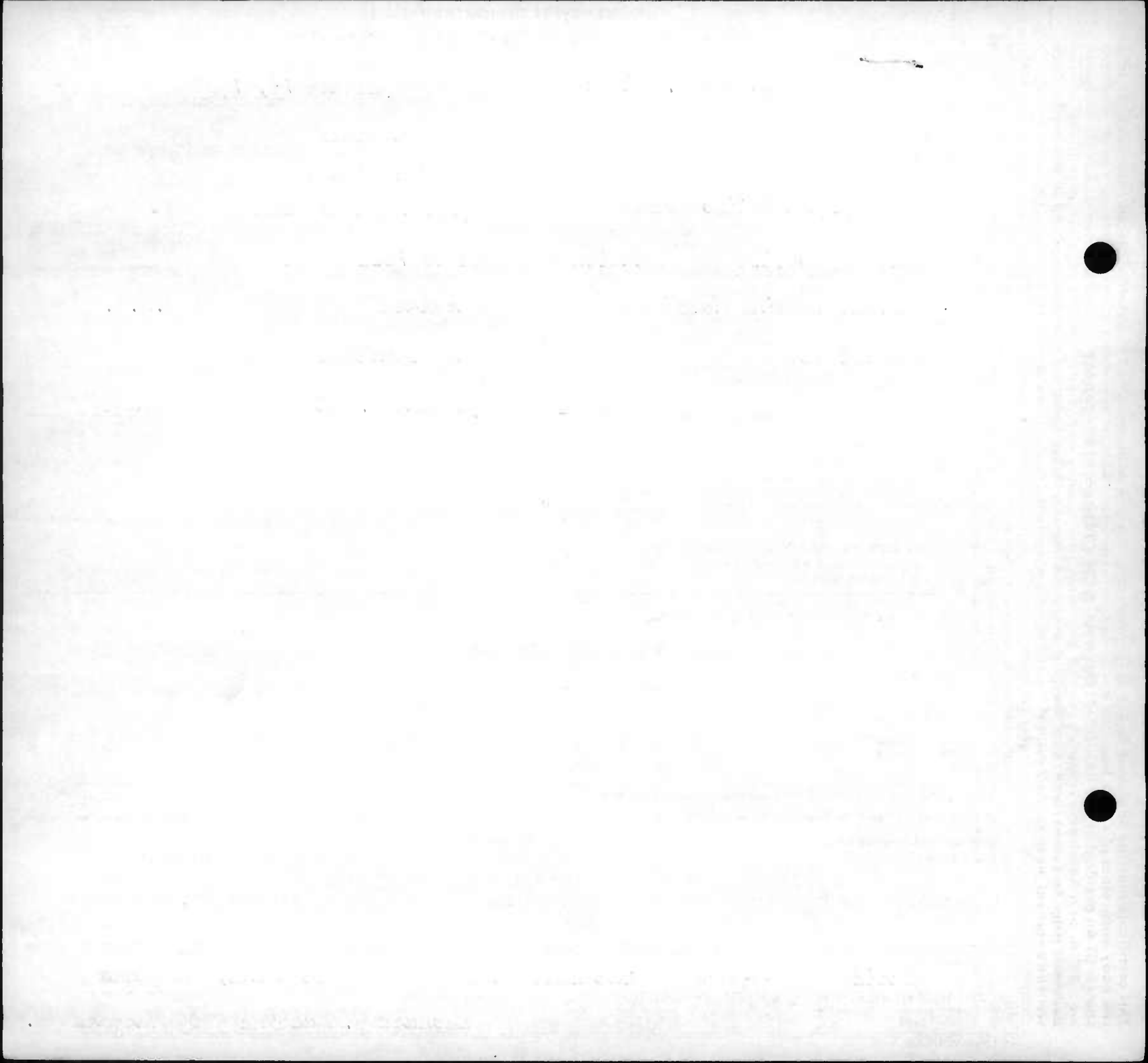
<p style="font-size: 24pt; margin: 0;">65 0557</p> <p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 24pt; margin: 0;">65 0557</p> <p style="font-size: 18pt; margin: 0;">Registered No.</p>	
<p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p> <p style="font-size: 18pt; margin: 0;">CITY HEALTH DEPARTMENT</p>			
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED* (Type or Print) <i>Joseph A. Rowley Sr.</i></p>		<p>2. DATE AND HOUR OF DEATH <i>January 12, 1965 1 P. M.</i></p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp.</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-38</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1331 Cedarcroft Rd.</i></p>	
<p>5. SEX <i>Male</i></p>	<p>6. RACE <i>White</i></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i></p>	<p>8. DATE OF BIRTH <i>10/23/1895</i></p>
<p>9. AGE (In years last birthday) <i>69</i></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>If Under 24 Hrs. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Postal Clerk</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></p>
<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>		<p>13. FATHER'S NAME <i>Joseph S. Rowley</i></p>	
<p>14. MOTHER'S MAIDEN NAME <i>Reardon</i></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i></p>	
<p>16. SOCIAL SECURITY NO. <i>217-38-7637</i></p>		<p>17. INFORMANT <i>Mrs. Antoinette T. Rowley,</i></p>	
<p>18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) <i>Coronary thrombosis</i> DUE TO (B) <i>Coronary insufficiency</i> DUE TO (C) _____</p>	
<p>INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i></p>		<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	
<p>19A. DATE OF OPERATION <i>0</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>1962</i> 19 to <i>Dec</i> 19 <i>65</i>, that (I) (we) last saw the deceased alive on <i>Dec. 11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>J. F. Palmisano</i></p>		<p>23B. DATE SIGNED <i>1/12/65</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>J. F. Palmisano,</i></p>		<p>23D. ADDRESS <i>6608 Loch Raven Blvd. Balto. Md. 21212</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i></p>		<p>24B. DATE <i>1/15/65</i></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <i>National Cemetery of Balto.</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Fink, M.D.</i></p>	
<p>25C. FUNERAL DIRECTOR'S ADDRESS <i>LEONARD J. RUCK, INC., BALTO., MD. 21214</i></p>		<p>25D. NAME OF FUNERAL HOME <i>LEONARD J. RUCK, INC., BALTO., MD. 21214</i></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0558</u>	
BIRTH NO. <u>65 0558</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>65 0558</u>					
1. NAME OF DECEASED (Type or Print) <u>Charles P. Kirby</u>		2. DATE AND HOUR OF DEATH <u>January 15, 1965</u> <u>6 A.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4848 Pimlico Road</u>		A. STATE <u>Maryland</u> B. COUNTY <u>27-17</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>4848 Pimlico Road</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 20, 1882</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman Hopkins Hospital</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lawrence</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-42-1339</u>		17. INFORMANT <u>Eleanor R. Kirby</u>	
				ADDRESS <u>same</u>	
18. <u>153.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Colon</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Since Sept 1964</u>		(A) DUE TO <u>Ameyrpn of Abdominal Aorta</u> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>"</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 16, 1946</u> to <u>1/15, 1965</u> , that (I) (we) last saw the deceased alive on <u>1/14, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel Morrison</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/15/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>SAMUEL MORRISON</u>		23D. ADDRESS <u>11 E. Chase St Balto 2, Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/18/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc 5305 Harford Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0559

BIRTH NO.

M.E. CASE NO. 65 0559

1. NAME OF DECEASED
 (Type or Print)

Nellie C. Filson

2. DATE AND HOUR OF DEATH

January 14, 1965 11 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
 HOSPITAL OR
 INSTITUTION

(If not in hospital or institution, give street
 address or location)

4913 Catalpha Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

27-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4913 Catalpha Road

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
 WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

Apr. 30, 1881

9. AGE (In years
 last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
 Months: Days: Hours: Min.

10. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if retired)

Dietician

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF
 WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Vandever

14. MOTHER'S MAIDEN NAME

Mary Swearingen

15. Was Deceased Ever in U. S. Armed Forces?
 (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
 SECURITY NO.

330-18-1205

17. INFORMANT

Mr. Lawrence Filson

ADDRESS

Same

18. 175-01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
 LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
 heart failure, osteoarthritis, etc. It means the disease,
 injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
 rise to the above cause (A) stating the
 UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) _____

INTERVAL BETWEEN
 ONSET AND DEATH

3 days

1 year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
 TO THE DEATH BUT NOT RELATED TO THE
 DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
 WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
 IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
 OR CONTRIBUTING ☐ CAUSE OF
 DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
 home, farm, factory, street, office bldg.,
 etc.)

21C. WHERE DID
 INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
 OF INJURY (Month) (Day) (Year) (Hour)
 (APPROX.)

21E. INJURY OCCURRED
 While At ☐ Not While ☐
 Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1962 19 to 1-14-65 19
 that (I) (~~we~~) last saw the deceased alive on 1-12-65 19 and that in (my) (~~our~~) opinion death occurred on the date
 and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE

C. W. Peake

M.D.

Attending
 Phys. ☒

Med.
 Director ☐

Staff
 Phys. ☐

23B. DATE SIGNED

1-15-65

23C. PHYSICIAN'S
 NAME (Type)

C. W. PEAKE

M.D.

23D. ADDRESS

4508 Harford Rd. Pk 14 Md

24A. BURIAL CREMATION,
 REMOVAL (Specify)

BURIAL

24B. DATE

1/19/65

24C. NAME OF CEMETERY or CREMATORY

Odd Fellows Cemetery

24D. LOCATION

Xenia, Illinois

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

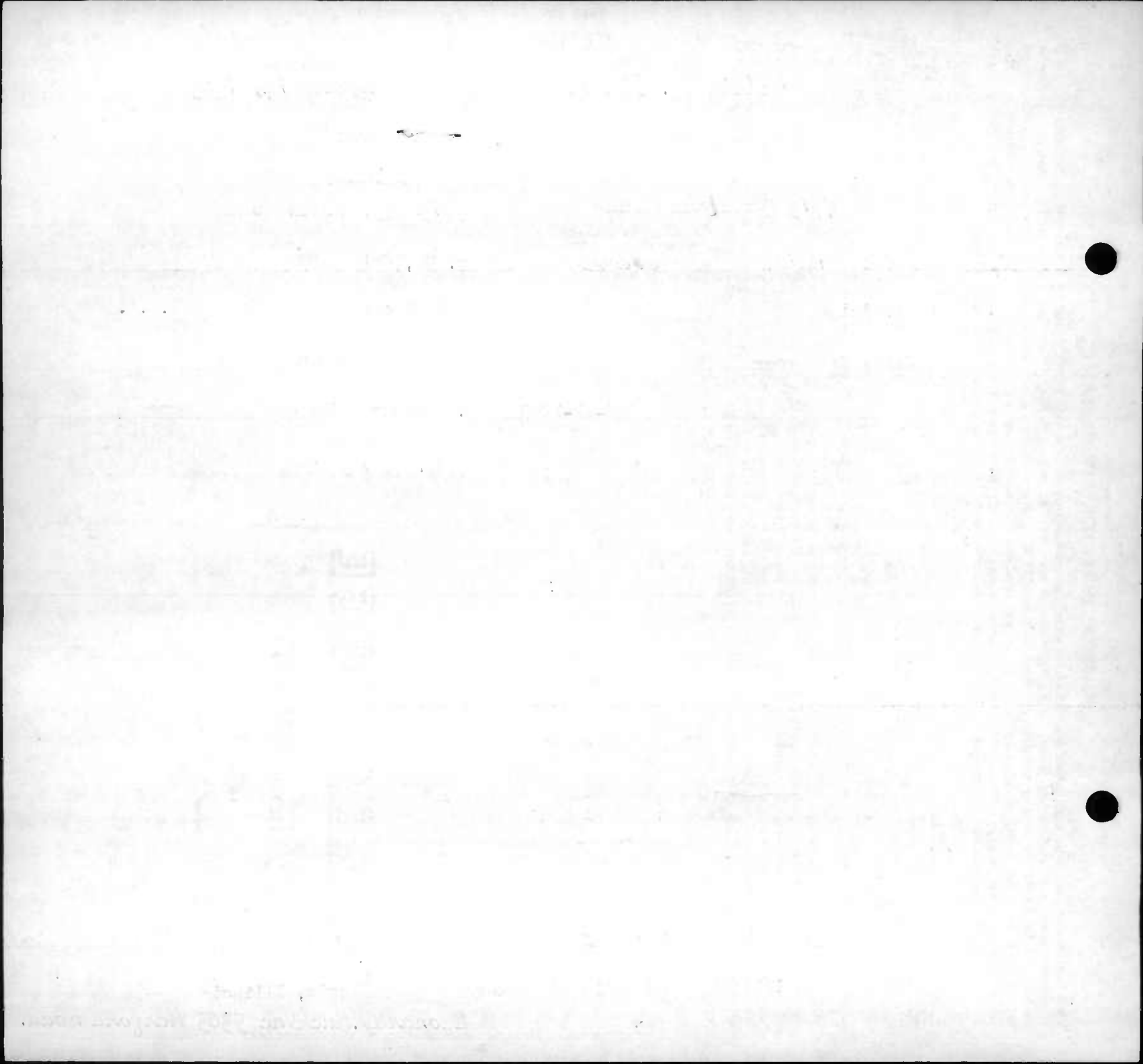
25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Road.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0560	
BIRTH NO. 65 0560		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) SMITH, DORIS HELEN		JANUARY 13, 1965 1:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CATONSVILLE	
		D. STREET ADDRESS (If rural, give location) 507 BLOOMINGDALE AVE. 53-00	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-5-17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (In years last birthday) 47
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME OTIS CLARK		14. MOTHER'S MAIDEN NAME FANNIE LEAR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO none		16. SOCIAL SECURITY NO. ?	
17. INFORMANT ST AGNES HOSPITAL RECORDS, WILKINS AND		ADDRESS CATON AVES. 21229	
18. 393X I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Acc. renal failure	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Uremia see to (A)	
		(C) CHF see to (A) (B)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-10- 19 65 to 1-13- 19 65 , that (I) (we) last saw the deceased alive on 1-13- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-13-65
23C. PHYSICIAN'S NAME (Type) D. Rodriguez		23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-16-65	24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	24D. LOCATION (City, town, or county) (State) BALTIMORE Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965	25B. NAME OF REGISTRAR Robert E. Farley M.D.	25C. FUNERAL DIRECTOR Ed. E. Schuyler Funeral Home 11th and Dr. Miller 2101 Frederick Ave.	

THE SOUTH AFRICAN

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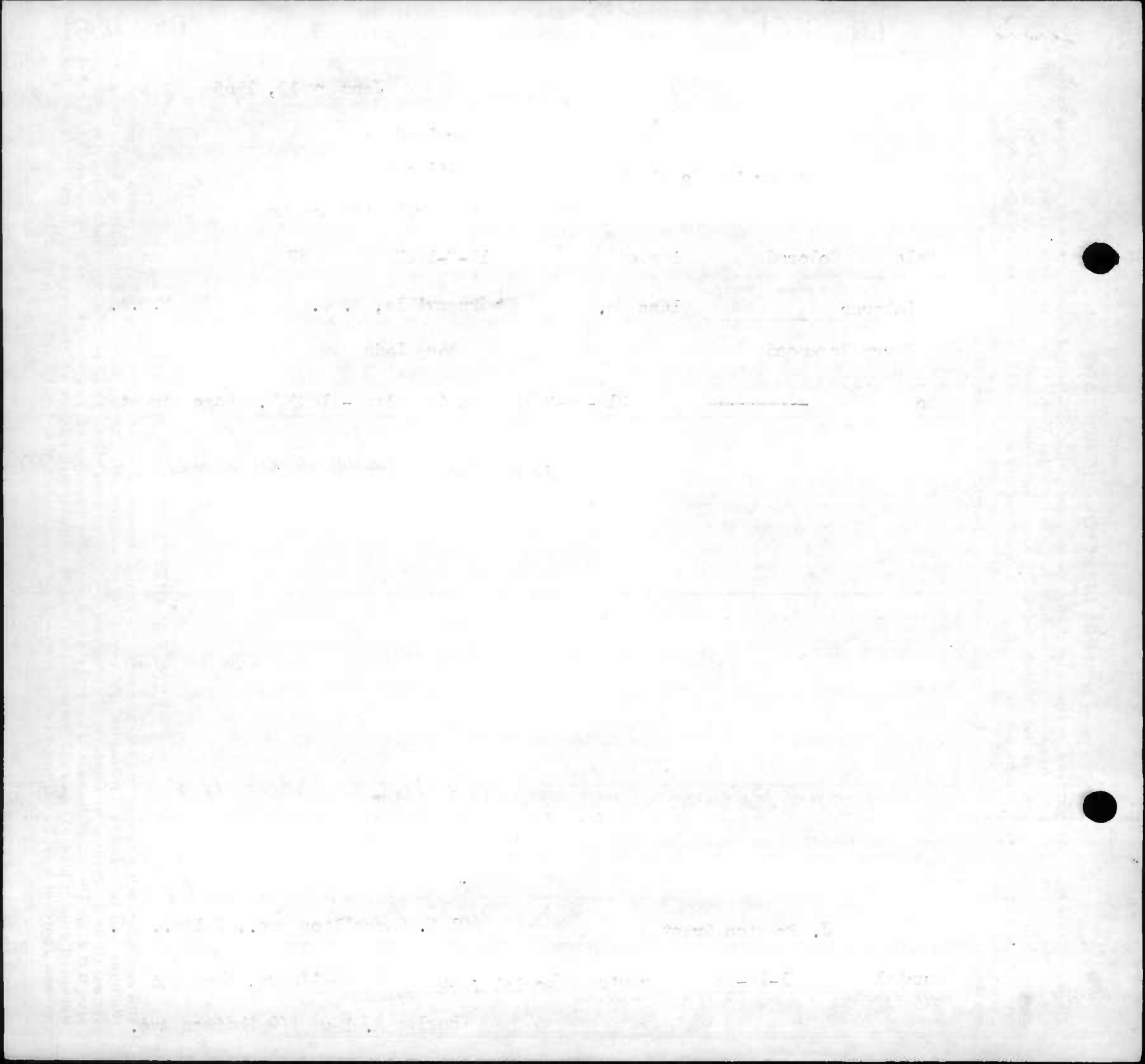
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0561				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0561	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MACK ROSEMOND				2. DATE AND HOUR OF DEATH January 13, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 226 Arlington Avenue			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-2-1882	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Glass Co.		11. BIRTHPLACE (State or foreign country) Greenville, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Perry Rosemond				14. MOTHER'S MAIDEN NAME Mary Ladd			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-7612		17. INFORMANT ADDRESS Marie Smith - 1803 E. Chase Street			
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASHDC Congestive Failure				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/8/65 to 1/8/65 , that (I) (we) last saw the deceased alive on 1/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Preston Grant				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) J. Preston Grant				23D. ADDRESS 601 N. Carrollton Ave., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-16-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 0562

BIRTH NO. 65 0562

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Mrs. MARY ANN PARENT

2. DATE AND HOUR OF DEATH

JANUARY 14, 1965 9⁰⁰ AM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital) or institution, give street address or location

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Balto.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 22.

53-00

D. STREET ADDRESS (If rural, give location)

66 Kinship Road.

5. SEX

FEMALE

6. RACE

W

7. ~~MARRIED~~ NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

June 24, 1903 62

AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Betha

14. MOTHER'S MAIDEN NAME

Agnes ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

CHARLES PARENT 66 KINSHIP RD

18. 430.01

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute respiratory failure
DUE TO Pneumonia + Spont. infarct.
(B) Septicemia
DUE TO Staph. (Staphylococcus)
Endocarditis.
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 7 19 65 to Jan. 14 19 65; that (I) (we) last saw the deceased alive on Jan 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Nieya G. Valle

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

January 14, 1965

23C. PHYSICIAN'S NAME (Type)

NIEYA G. VALLE

M.D.

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1-18-65

24C. NAME OF CEMETERY or CREMATORY

HOLY ROSARY

24D. LOCATION (City, town, or county) (State)

BALTIMORE Co. MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

25B. NAME OF REGISTRAR

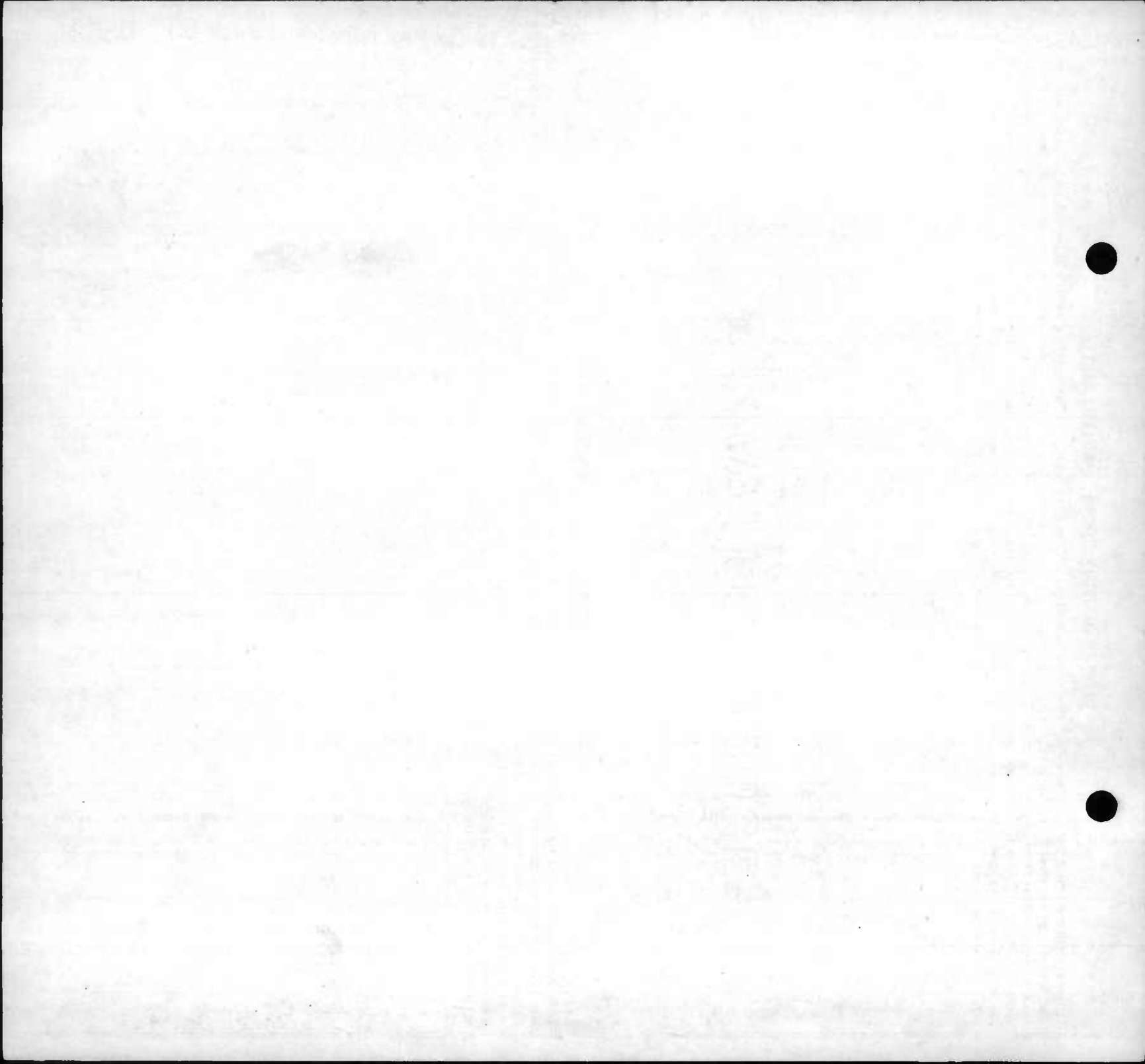
Robert E. Farley

25C. FUNERAL DIRECTOR

JOHN M. WEDDERBURN'S INC.

ADDRESS

401 S. CHESTER ST.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0563	
BIRTH NO. 65 0563				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Mr Robert Lohmyer</i>	
2. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH <i>1-18-65 9-20 P.M.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home & Hosp.</i>		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>203</i>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>12-18-1886</i>	
<i>Retired</i>		<i>Retired</i>		9. AGE (In years, lost birthday) <i>78</i>	
13. FATHER'S NAME <i>Robert Lohmyer</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Weber</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-34-2503</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
17. INFORMANT <i>THELMA SMITH 2107 EASTERN AVE</i>		ADDRESS		18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		CAUSE OF DEATH (A) <i>Rt Hemiplegia</i> DUE TO (B) <i>Cerebrovascular hemorrhage</i> DUE TO (C)	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-13-65</i> 19 to <i>1-15-65</i> 19, that (I) (we) last saw the deceased alive on <i>1-15-65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Antoine Arrage</i> M.D.				23B. DATE SIGNED <i>1-15-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>ANTOINE ARRAGE</i> M.D.				23D. ADDRESS <i>Church Home & Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-19-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>PARKWOOD CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE CO MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>	
25C. FUNERAL DIRECTOR <i>John M. Weber & Sons Inc.</i>		25D. ADDRESS <i>401 S. Chester St</i>			

1
C. 400

65 0564

BALTIMORE CITY HEALTH DEPARTMENT

65 0564

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59337

1. NAME OF DECEASED
(Type or Print)

LEO CALLOW

2. DATE AND HOUR PRONOUNCED DEAD

January 16, 1965 10:25 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

214 S. Collington Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 16, 1902

9. AGE (In years last birthday)

62

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Scheniut tire Co Washington D.C.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Callow

14. MOTHER'S MAIDEN NAME

Rose ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL SECURITY NO.

218-05-4168

17. INFORMANT

ADDRESS

Genevieve Callow 214 S Collington

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/20/65

23C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION (City, town, or county)

Baltimore Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John M. Weber & Sons, Inc.
401 S. Chester St

ADDRESS

VA

Nov. 1971

Memorandum for the Director, FBI

Re:

Subject: [Illegible]

(S)

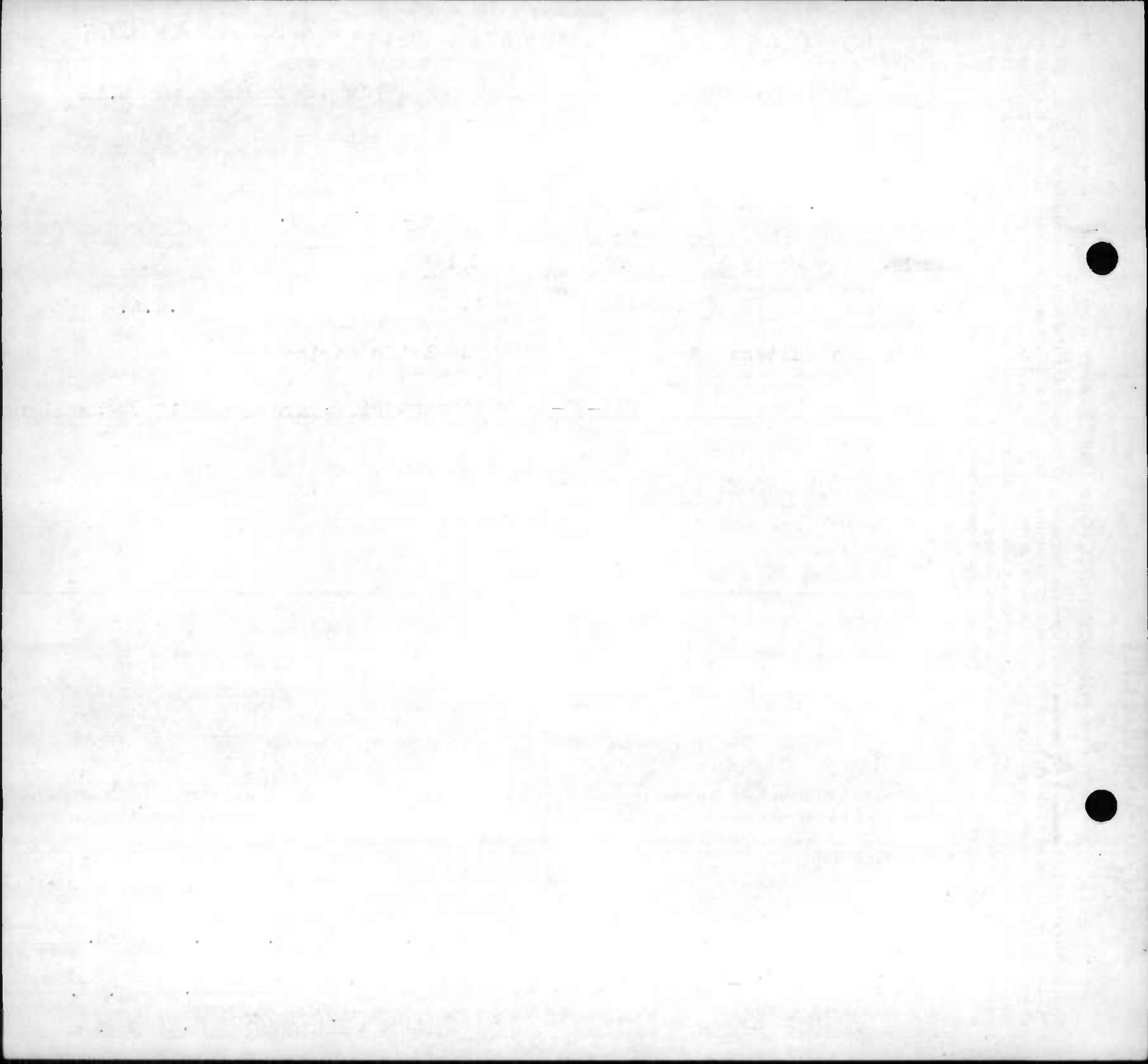
(M)

Very truly yours,
John E. [Illegible]
Director

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

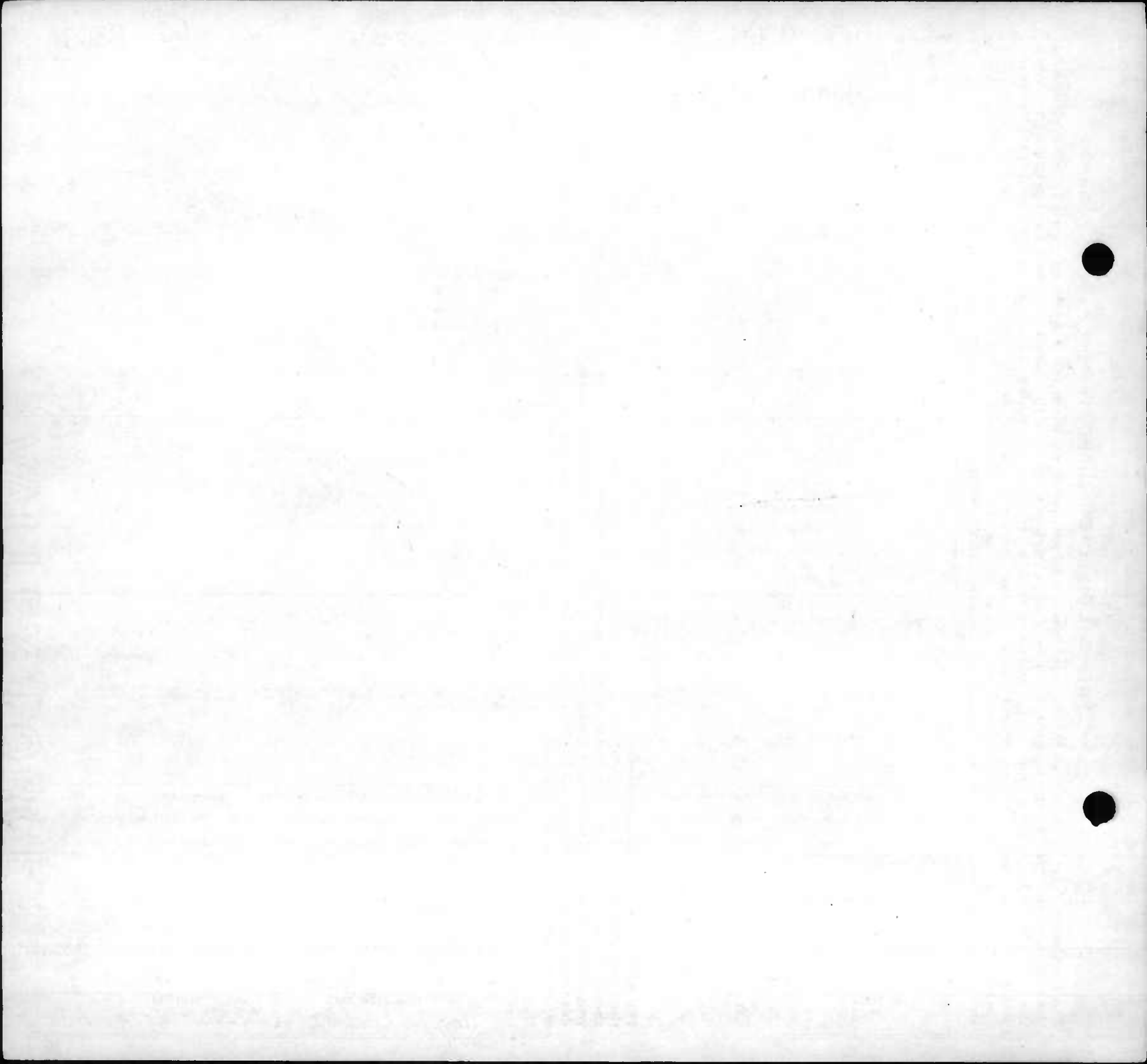
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0565</u>	
BIRTH NO. <u>65 0565</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>DiPietro, Fannie</u>			<u>January 16 1965</u> <u>9:10P</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			A. STATE <u>Maryland</u>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore#2</u>		
			D. STREET ADDRESS (If rural, give location) <u>1015 Stiles St.</u>		
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/13/95</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Vincenzo Juliano</u>			14. MOTHER'S MAIDEN NAME <u>Adelaide Morino</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-20-4249</u>	17. INFORMANT <u>Vincent Di Pietro (Son)</u>		
			ADDRESS <u>3915 Brehms Lane</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>157X I</u>			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
			(A) <u>Adeno carcinoma, Ampullae of Vater</u> DUE TO		
			(B) <u>Carcinoma of Pancreas</u> DUE TO		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 10 1965</u> to <u>January 16 1965</u> , that (I) (we) last saw the deceased alive on <u>January 16 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. G. Sagasi</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 16 1965</u>
23C. PHYSICIAN'S NAME (Type) <u>Gloerito G. Sagasi</u>			23D. ADDRESS M.D. <u>1400 N. Caroline St. Balto. 21213 Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/20-65</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		24D. LOCATION (City, town, or county) (State) <u>4430 Belair Rd. Balt Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR <u>Frank Dellaliga</u>	
				ADDRESS <u>22 S. High St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0566	
BIRTH NO. 65 0566		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Thomas		2. DATE AND HOUR OF DEATH Jan 12 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 503 W. Lanvale St				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 503 W. Lanvale St 1702 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland D. STREET ADDRESS (If rural, give location) 503 W. Lanvale St			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 8 1874	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Matilda Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 221-03-3283		17. INFORMANT ADDRESS Ida Williams 4119 13th Place N.E. Wash. D.C.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Coronary Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Elephantiasis Both Leg				INTERVAL BETWEEN ONSET AND DEATH 3 mos 5 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-12 1964 to 1-12-65 19 , that (I) (we) last saw the deceased alive on 1-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. Franklin Phillips M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips				23D. ADDRESS 558 McQueen St Baltimore			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-16-65		24C. NAME OF CEMETERY OR CREMATORY MT Auburn Cem		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Joseph H. Russ 2222 W. North Av			



1
M. 620

65 0567

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 0567

BIRTH NO.

M.E. CASE NO. 59301

1. NAME OF DECEASED (Type or Print) FRANK MARSH			2. DATE AND HOUR PRONOUNCED DEAD 1/12/65 1:40 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 11-03 D. STREET ADDRESS (If rural, give location) 212 W. Monument St.		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov 15, 1922	9. AGE (In years last birthday) 42	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Union Cou., N.C.	
13. FATHER'S NAME Frank B. Marsh			14. MOTHER'S MAIDEN NAME Eula Deese		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) - - -			16. SOCIAL SECURITY NO. 237-26-9131		
17. INFORMANT Mr. W.A. Marsh (Brother)			ADDRESS Marshville, N.C.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			INTERVAL BETWEEN ONSET AND DEATH		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 2			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) yes		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
23. ACTUAL SIGNATURE EXAMINER'S NAME (Type) W.U. Spitz, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL					
23B. DATE Jan 12, 65					
23C. NAME OF CEMETERY or CREMATORY Marshville Cemt					
23D. LOCATION (City, town, or county) (State) Marshville, N.C.					
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1965					
24B. NAME OF REGISTRAR Robert E. Taylor, M.D.					
24C. FUNERAL DIRECTOR MORGAN & SON - Marshville, N.C.					

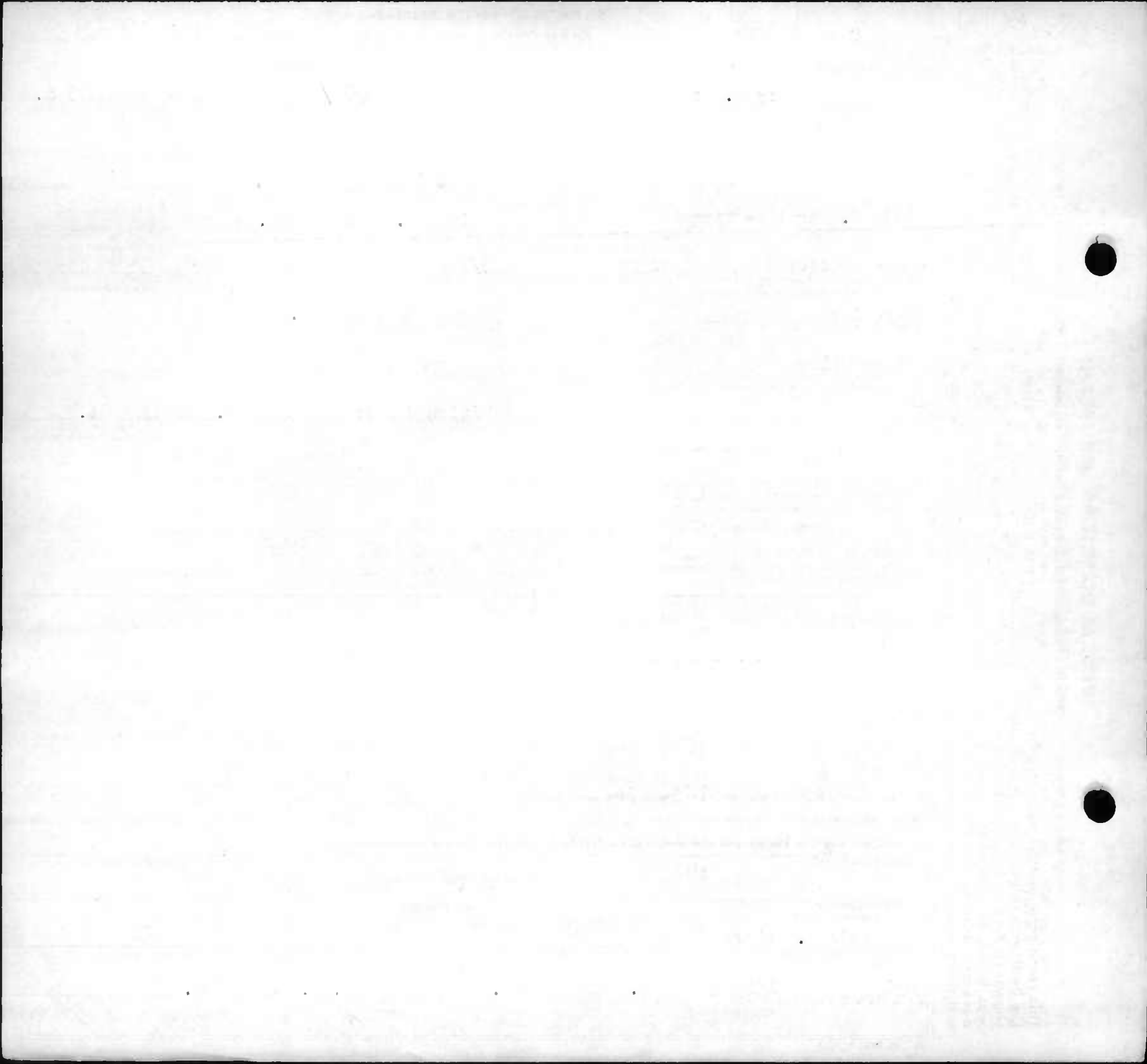
WALTER
BROS
INC
CHICAGO
ILL

Dippel Bros

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

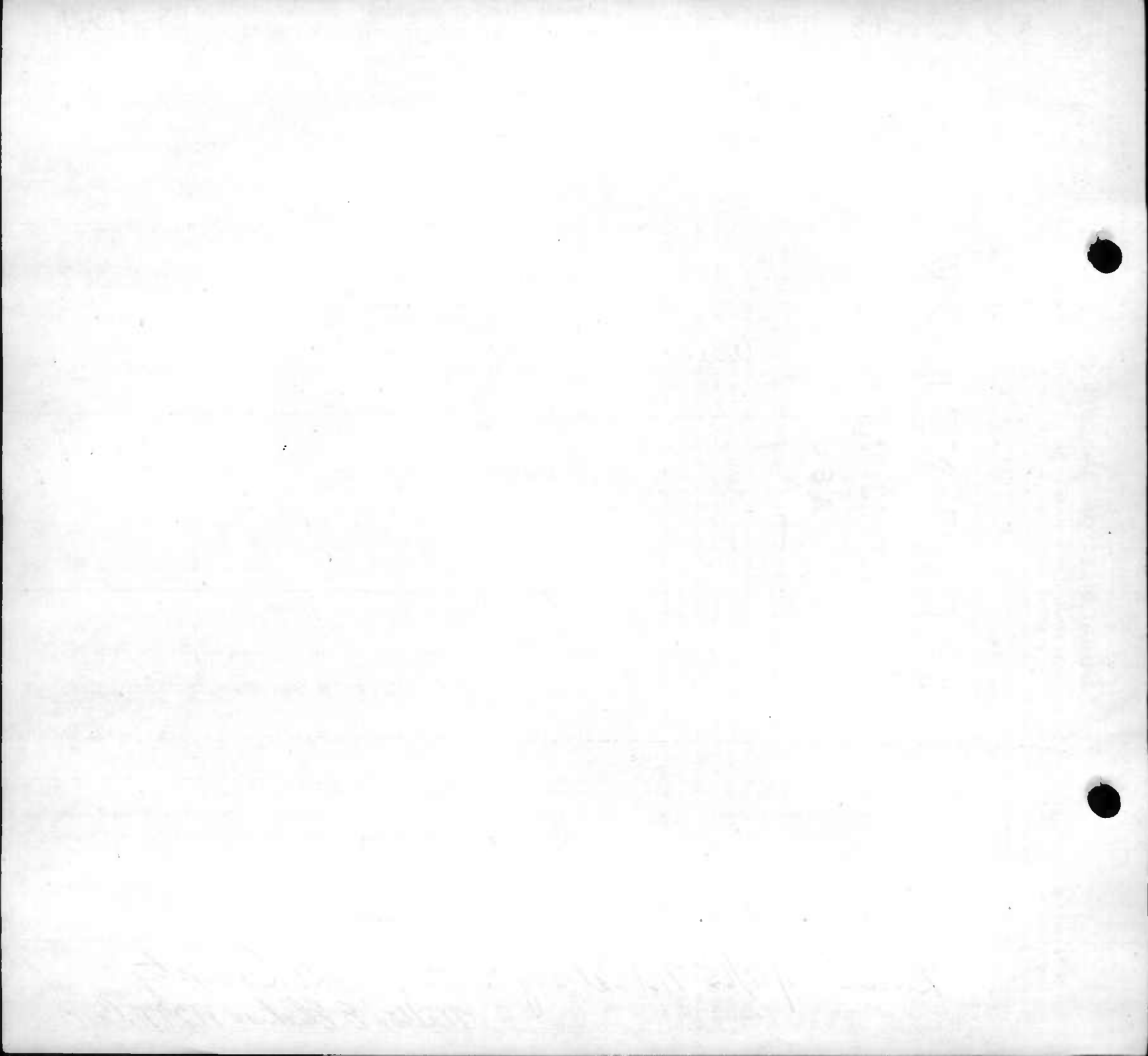
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 0568	
BIRTH NO. 65 0568					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mary E. Goings		1/14/65 1:05 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
1834 N. Caroline Street		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1834 N. Caroline St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Colored	Widow	3/10/1888	76	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
				Caroline County Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James Wilson		Emma ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Vivian Jarvis 1834 N. Caroline St.	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Crown Disease		3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1 19 62 to Jan 14 19 65 , that (I) (we) last saw the deceased alive on Jan 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis A. Johnson M.D.				23B. DATE SIGNED Jan 18-65	
23C. PHYSICIAN'S NAME (Type) Louis A. Johnson				23D. ADDRESS 301-E-22 St. Balt 18 Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/18/65		Mt. Calvary Cem.	
				A. A. County Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1965		Robert E. Taylor M.D.		John T. Clicker 1129 N. Caroline St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

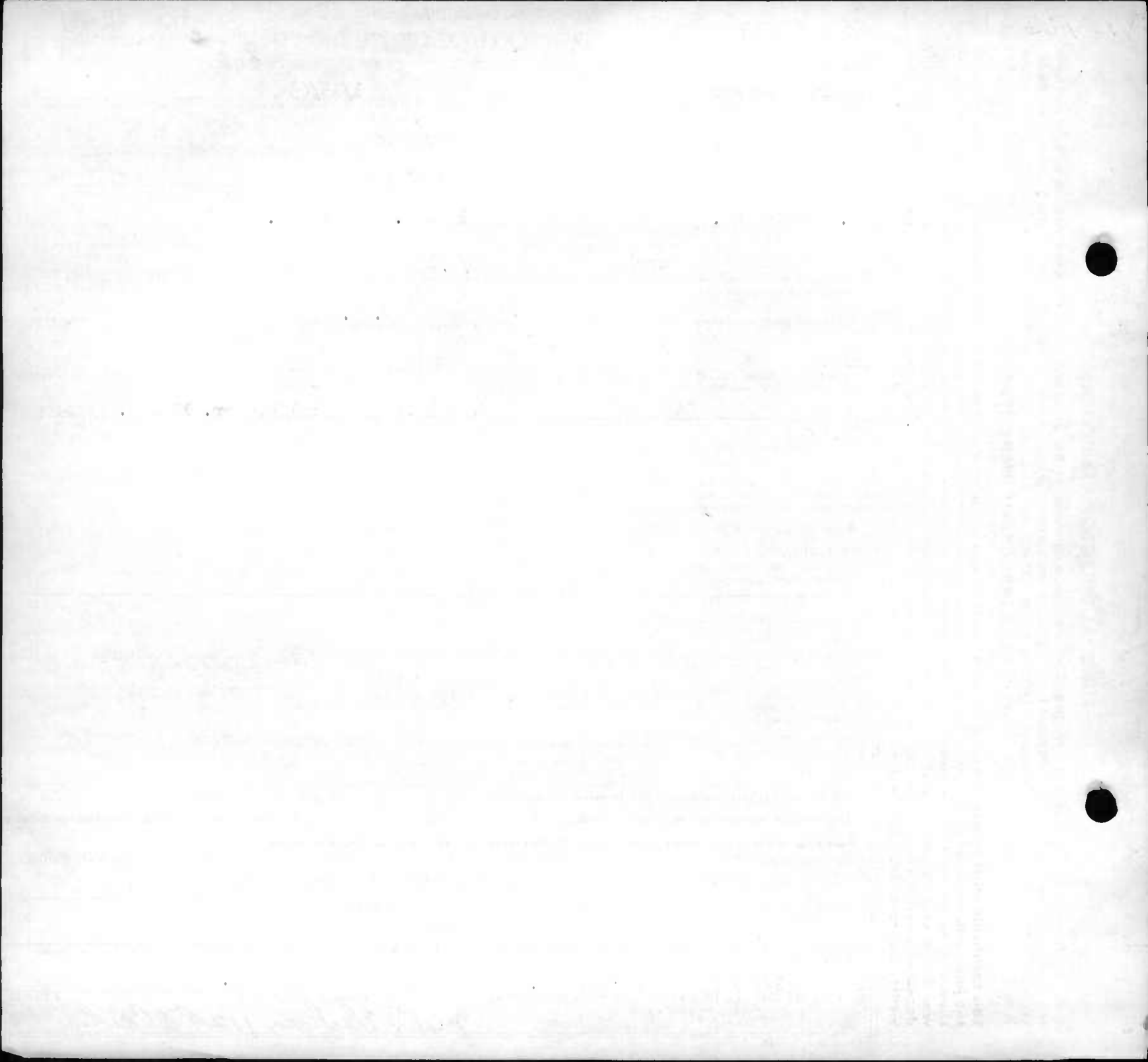
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0569	
BIRTH NO. 65 0569		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Allen, Noddy (Nodie)		2. DATE AND HOUR OF DEATH 1/16/65 1020 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		A. STATE MD B. COUNTY Besto			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location) 1625 E Madison			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Unkn	8. DATE OF BIRTH Unkn	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unkn		10B. KIND OF BUSINESS OR INDUSTRY Unkn		11. BIRTHPLACE (State or foreign country) Unkn	
12. CITIZEN OF WHAT COUNTRY? Unkn		13. FATHER'S NAME Thomas Allen			
14. MOTHER'S MAIDEN NAME Timpey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unkn			
16. SOCIAL SECURITY NO. Unkn		17. INFORMANT A. Barkerville		ADDRESS Same	
18. 420.1 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Myocardial Infarction (probable)			
ANTECEDENT CAUSES		(B) Generalized arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		none			
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/15/65 19 to 1/16 19 65 , that (I) (we) last saw the deceased alive on 1/16/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. R. Wagner				23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type) DR. JOHN R. WAGNER				23D. ADDRESS JHH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A.A. County		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR William E. Elickson			
25D. ADDRESS 1129 N. Carroll St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

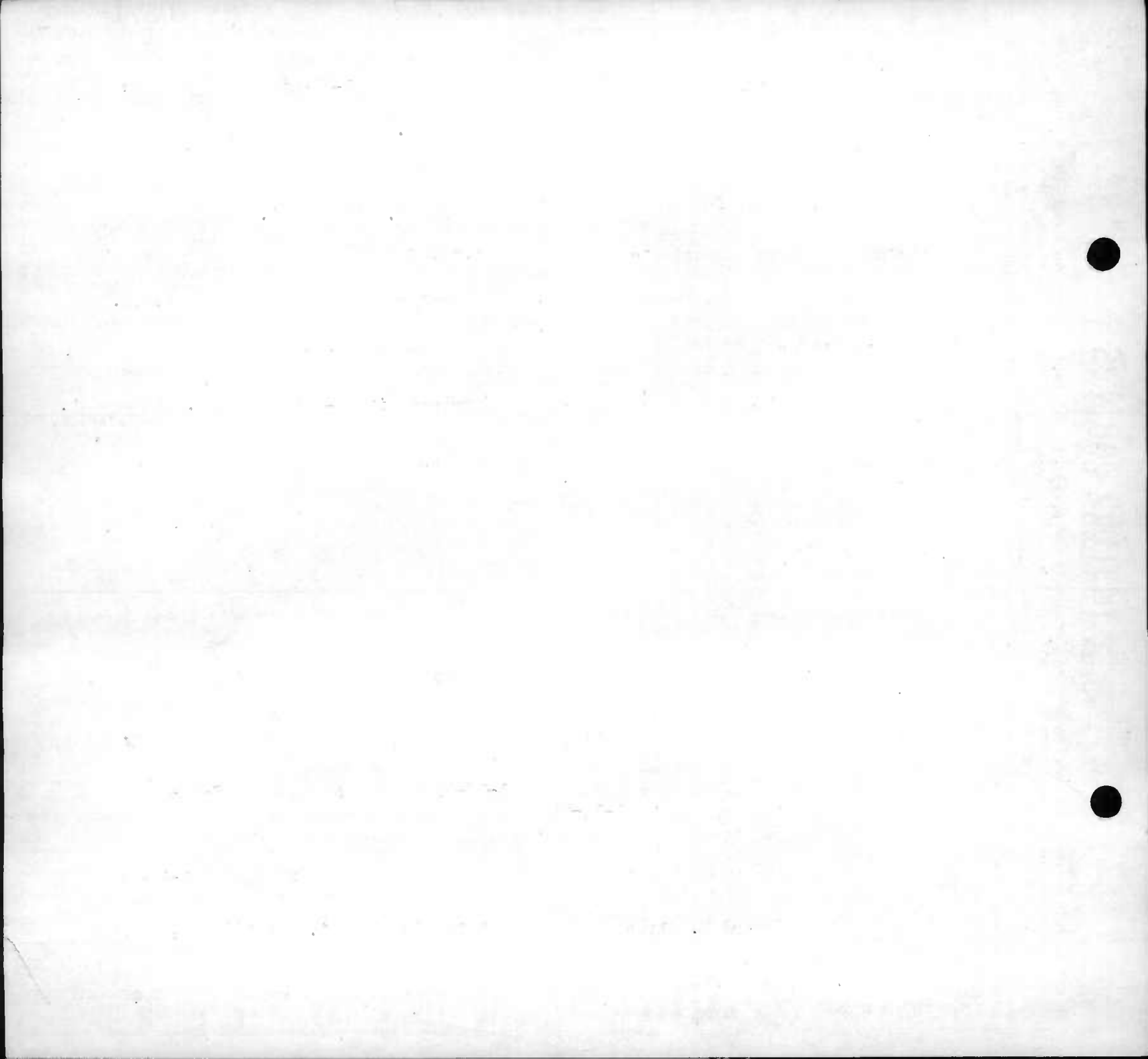
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 0570					
BIRTH NO. 65 0570					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Bertha Lawson Woolford					2. DATE AND HOUR OF DEATH 1/15/65 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1741 E. Preston St.					A. STATE Maryland					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
					D. STREET ADDRESS (If rural, give location) 1741 E. Preston St.					
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4/1/1902	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Raleigh N. C.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Lawson					14. MOTHER'S MAIDEN NAME Fannie ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph Westley Woolford Sr. 1741 E. Preston St				
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from May 19 63 to Jan 19 65 , that (I) (we) last saw the deceased alive on Jan 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Royston B. Scott M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED Jan 18, 65		
23C. PHYSICIAN'S NAME (Type) ROYSTON B. SCOTT M.D.					23D. ADDRESS 1801 W Baltimore St, Baltimore Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park			24D. LOCATION (City, town, or county) (State) Arbutus Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			25B. NAME OF REGISTRAR Robert E. Jackson			25C. FUNERAL DIRECTOR J. T. Eickman			ADDRESS 1129 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65, 0571				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0571	
M.E. CASE NO. 05-01216				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby of Barbara Wilkes				2. DATE AND HOUR OF DEATH 7-13-65 9:30p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 19-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 404 N. Gilmore St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 7-13-65	9. AGE (In years last birthday) 7	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10B. KIND OF BUSINESS OR INDUSTRY none		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Wilkes				14. MOTHER'S MAIDEN NAME Barbara Swain			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wd# or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Barbara Wilkes-mother 404 N. Gilmore St.	
18. 726X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Immaturity DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-13-65 19 to 7-13-65 19, that (I) (we) last saw the deceased alive on 7-13-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Vincent R. Blake				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-13-65	
23C. PHYSICIAN'S NAME (Type) Vincent R. Blake				23D. ADDRESS M.D. 1514 Division St. Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JAN 15 1965		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

LOUISE JENKINS

2. DATE AND HOUR PRONOUNCED DEAD

1-10-65

4:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1517 N. Monroe Street - 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXXXX~~ Hypertensive heart disease with
myocardial insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-11-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

JAN 15 1965

23C. NAME OF CEMETERY or CREMATORY

UNIVERSITY MEDICAL SCHOOL

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

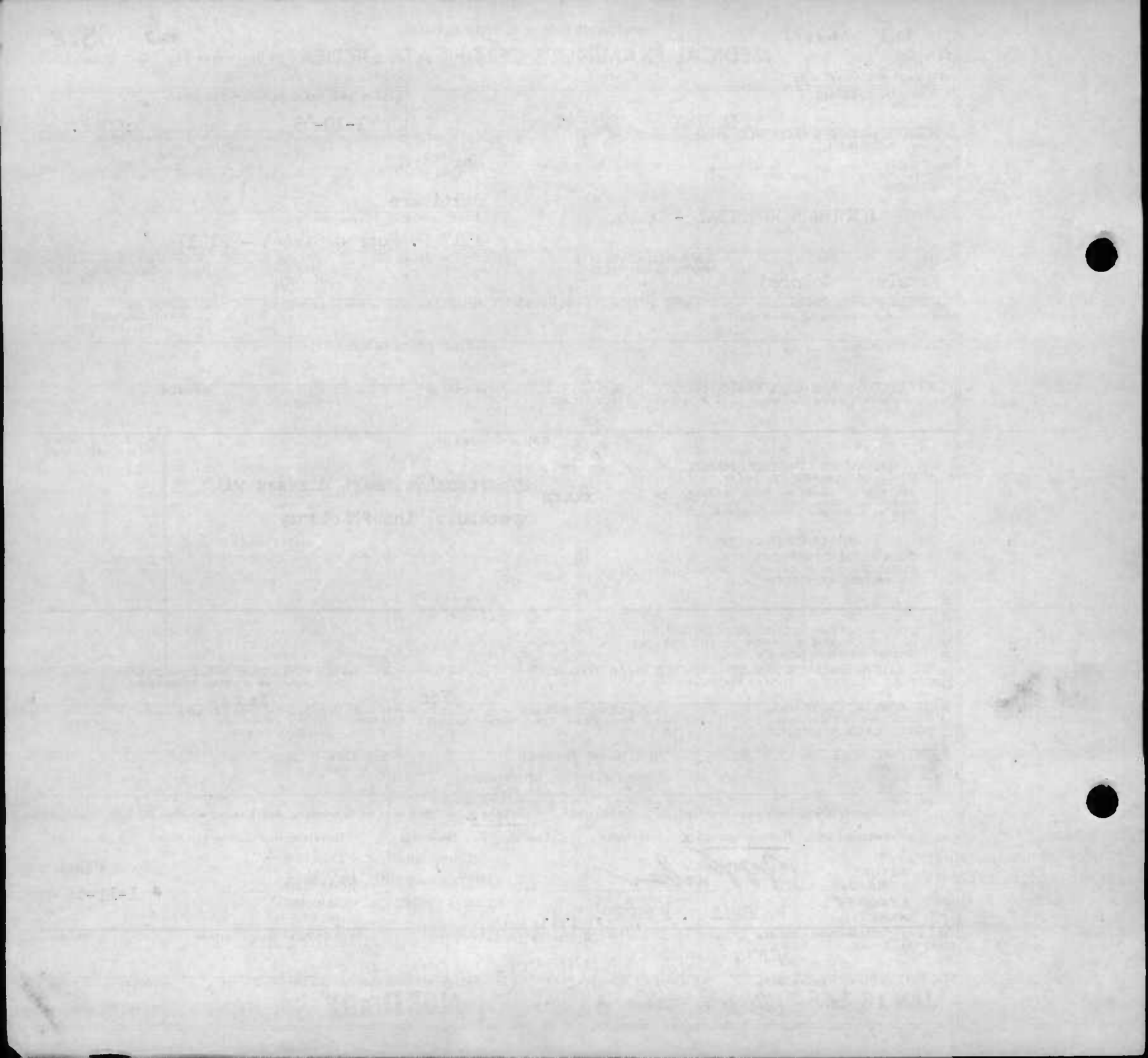
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

MORTUARY SERVICE - BCHD

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 0573

BIRTH NO. 65 0573

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Cecilia Hammel (Sehnke)

2. DATE AND HOUR OF DEATH

JANUARY 12, 1965

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

720 SOUTH LAKEWOOD
AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

720 S. LAKEWOOD AVE.

5. SEX

FEMALE WHITE

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

10-1-1913

9. AGE (In years
last birthday)

51 YRS

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

FELIX TYSZKIEWICZ

14. MOTHER'S MAIDEN NAME

JADWIGA LANENCKI

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

220-24-3735

17. INFORMANT

MISS JOAN SEHNKE 720 S. LAKEWOOD AVE

ADDRESS

18. 163X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Obducoconduca At Lung 3 2002

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 19 63 to Jan 12 19 65.
that (I) (we) last saw the deceased alive on Jan 11 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Theodore T. Niznik M.D.

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

1-13-65

23C. PHYSICIAN'S
NAME (Type)

T. T. NIZNIK M.D.

23D. ADDRESS

429 S. Chester St

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL 1/15/65

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

Holy Rosary Cem.

24D. LOCATION

BALTIMORE CO. MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

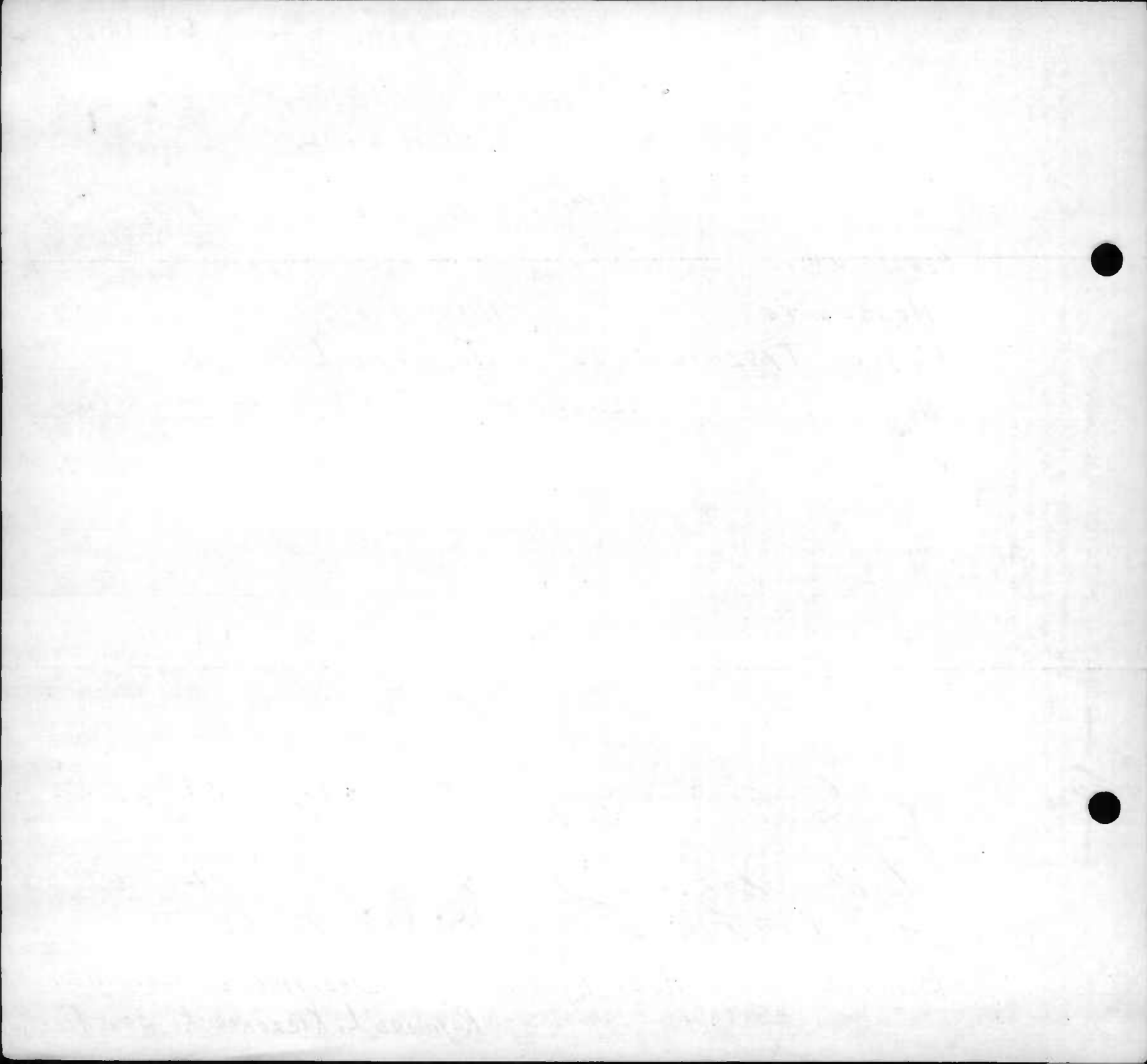
25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

RAYMOND L. KACZOROWSKI 2525 FLEET ST.

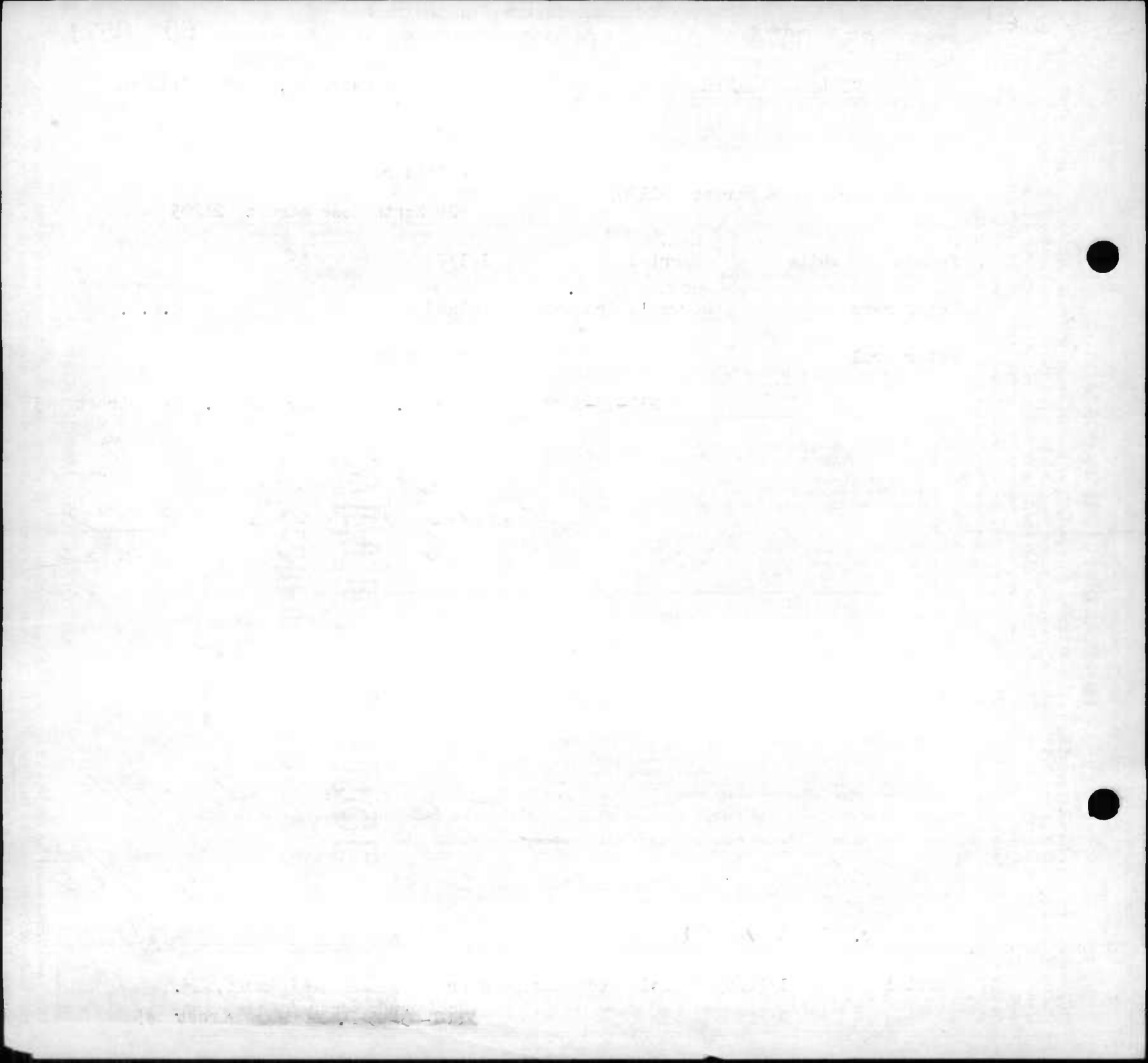
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

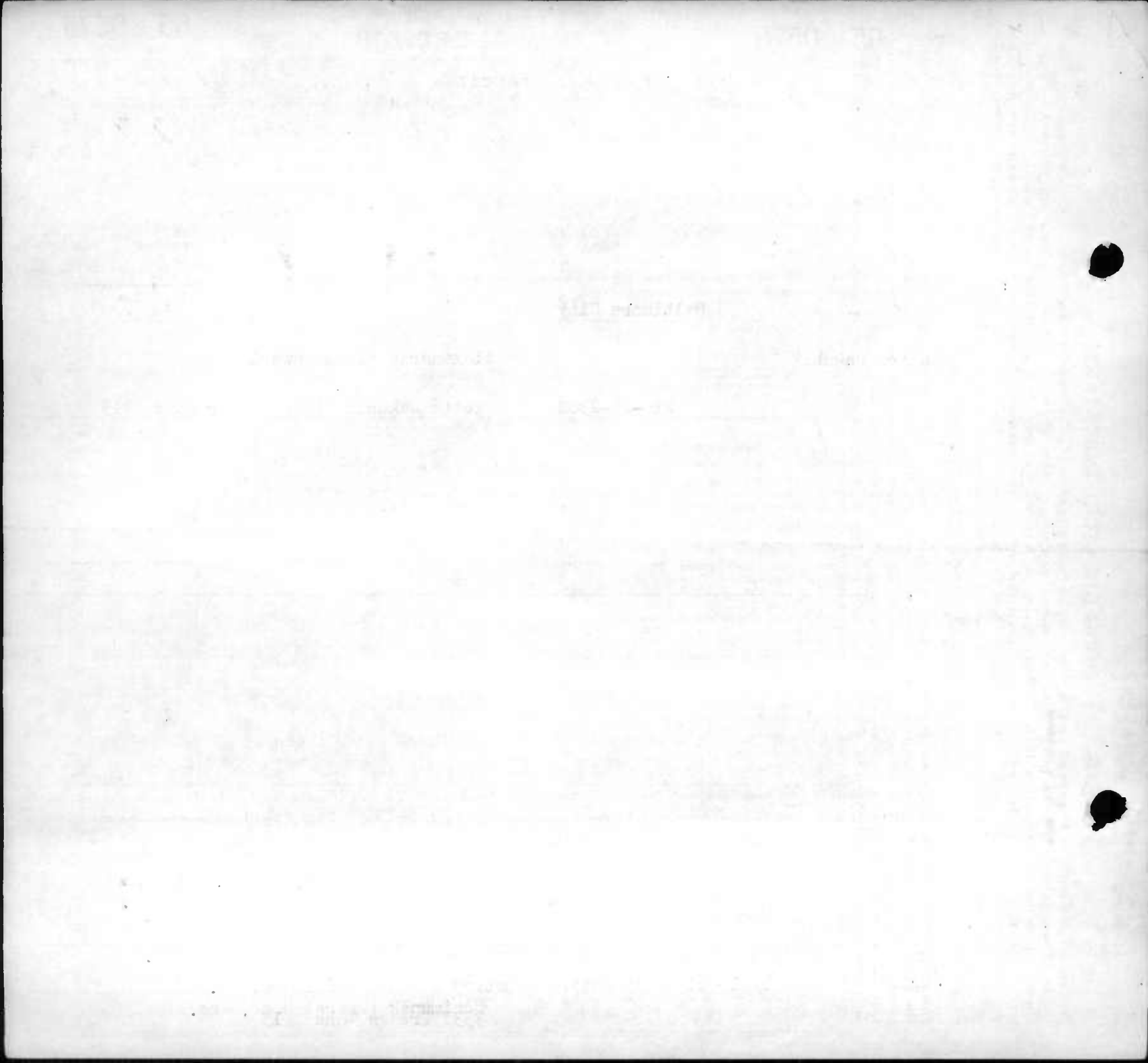
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0574</u>	
BIRTH NO. <u>65 0574</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>VIOLA SHOWALTER</u>		2. DATE AND HOUR OF DEATH <u>January 16, 1965 8:30 pm</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>429 North Rose Street 21205</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>602</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>429 North Rose Street 21205</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/1/02</u>	9. AGE (In years last birthday) <u>63</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Dvorak Bros. Dovrak's Brothers</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Peter Krol</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Yanka</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-2278</u>		17. INFORMANT ADDRESS <u>Robert M. Showalter 429 N. Rose Street #5</u>			
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH <u>Myocardial Infarction</u> DUE TO <u>Coronary Artery Disease</u> DUE TO <u>Cholesterol Metabolism</u> DUE TO <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>5 days</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1965</u> to <u>January 16 1965</u> . that (I) (we) last saw the deceased alive on <u>Jan 15 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Albert E. Sokorski</u> M.D.				23B. DATE SIGNED <u>1/18/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Albert Sokorski</u>				23D. ADDRESS <u>2939 E. Madison St.</u> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Schimmey's Funeral Home, Inc.</u>		ADDRESS <u>2601-03-05 E. Madison Street #5</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

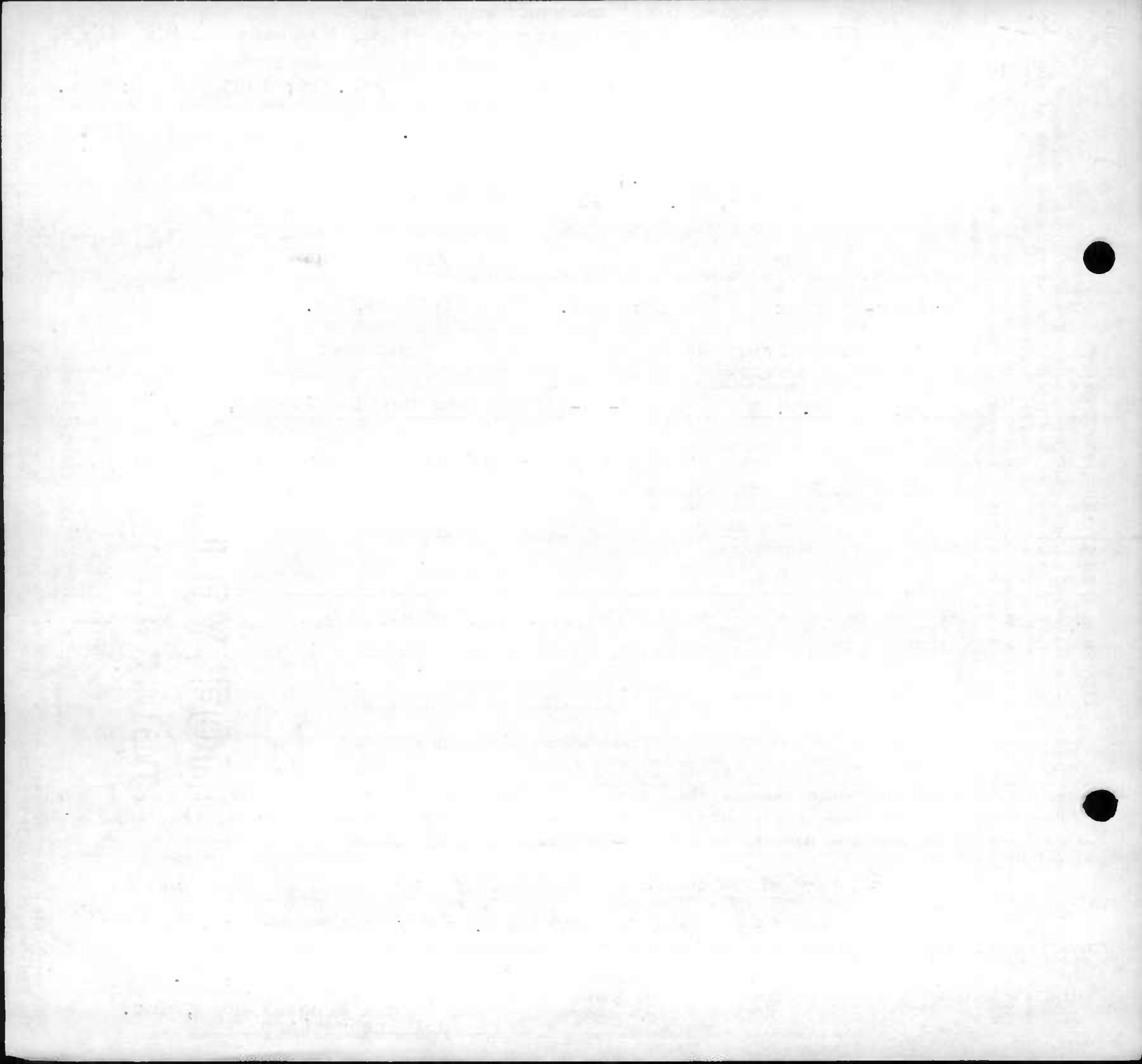
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0575					CERTIFICATE OF DEATH		Registered No. 65 0575		
1. NAME OF DECEASED (Type or Print) JAKUBIK EDWARD Francis					2. DATE AND HOUR OF DEATH 1/16/65 12/25 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
Lutheran Hospital of Maryland					State Maryland		27-01		
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					3912 Belair Road				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
male	white	married		1/16/26	38				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Mechanic			Baltimore City		U.S.A		U.S.A		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Walter Jakubik					Alexandria Mieduszenski				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
			216-20-2362		chart. Betty Jakubik			3912 Belair Road #13	
18. 162.1 I					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
					Bronchogenic carcinoma with generalized metastasis				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					cerebral embolism				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 1-1-65 19 65 to 1-16-65 19 65 , that (I) (we) last saw the deceased alive on 1-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
CH. ADIB M.D.								1/16/65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
CH. ADIB M.D.					M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		1/19/65		Holy Rosary Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 18 1965		Robert E. Taylor, M.D.		Schimunek Funeral Home, Inc.		3331 Brenns Lane #13			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

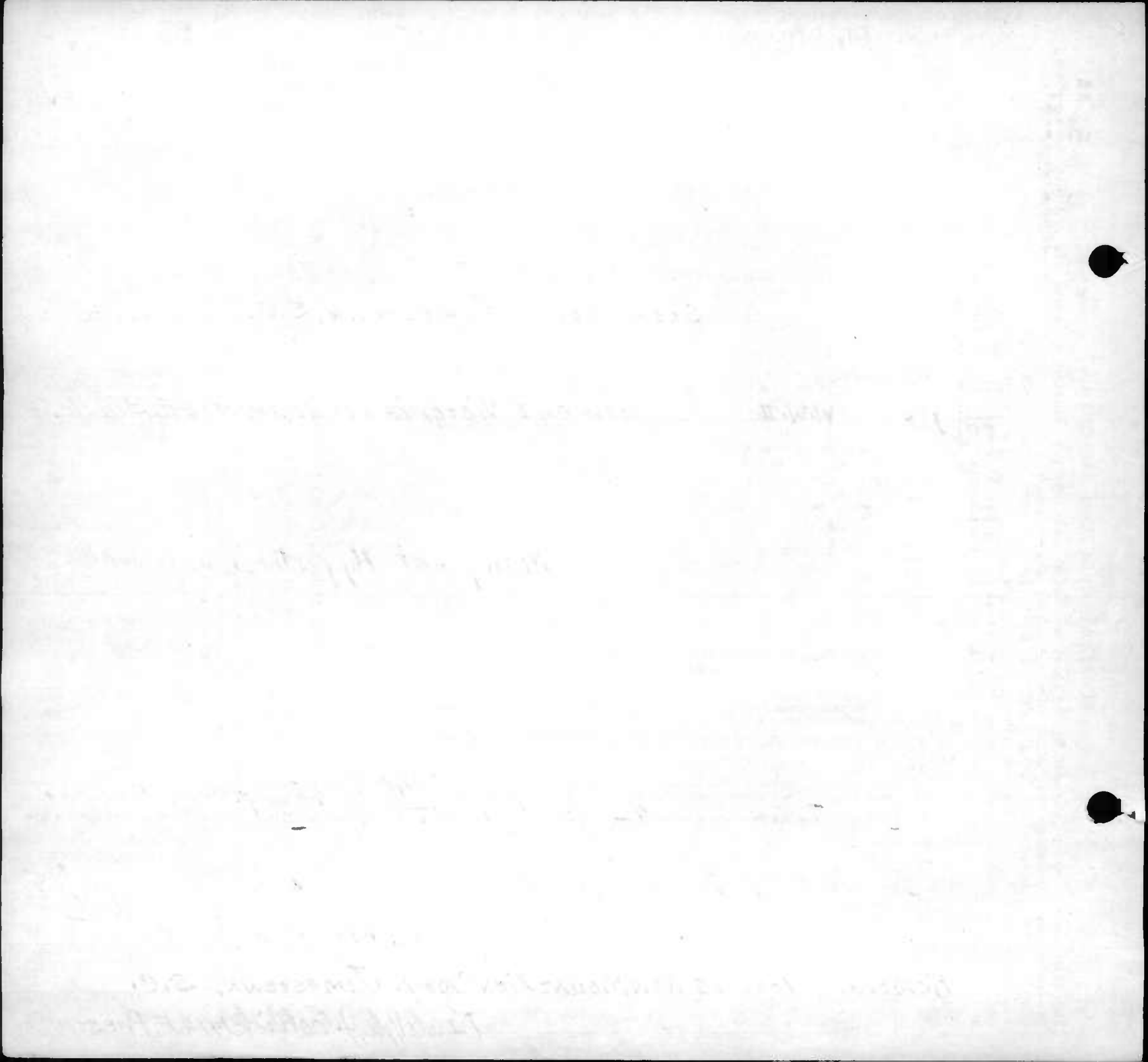
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0576		CERTIFICATE OF DEATH		Registered No. 65 0576	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANK JOSEPH ZAHRADKA		Jan. 16, 1965 8:30 a.m. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3226 Brendan Ave., Baltimore, Md., 21213		A. STATE Md. B. COUNTY 26-03			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3226 Brendan Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/2/15	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor-Presser		10B. KIND OF BUSINESS OR INDUSTRY Dvorak Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frank Zahradka			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. 2			16. SOCIAL SECURITY NO. 215-09-1157		17. INFORMANT Rose Petti Zahradka, wife, above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Lung			INTERVAL BETWEEN ONSET AND DEATH years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Rheumatoid Arthritis			years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 1 - 1964 to Jan 16 - 1965 , that (I) (we) last saw the deceased alive on Jan 8 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George Sawyer				23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER, M.D.				23D. ADDRESS 4808 Harford Rd. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/65		24C. NAME OF CEMETERY or CREMATORY Bohemian National Cem	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Sawyer, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0577				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0577	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SARGENT FORDHAM				2. DATE AND HOUR OF DEATH 1-16-65 4.35 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY			
				D. STREET ADDRESS (If rural, give location) 1003 EAST BIDDLE STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-3-21	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Jamestown, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANSEL FORDHAM				14. MOTHER'S MAIDEN NAME LUCY WASHINGTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.II				16. SOCIAL SECURITY NO. 250-16-0613		17. INFORMANT Victoria Fordham	
18. 445X1				CAUSE OF DEATH		ADDRESS 1003 E. Biddle St.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) Malignant Hypertension		6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 4th 1965 to January 16 1965 , that (I) (we) last saw the deceased alive on 4:35 am January 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herbert J. Harwick M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 16, '65	
23C. PHYSICIAN'S NAME (Type) HERBERT J. HARWICK M.D.				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY New Mount Zion Cmt'y. Jamestown, S.C.		24D. LOCATION (City, town, or county) (State) Jamestown, S.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 1412 E. Preston St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0578	
BIRTH NO. 65 0578				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Hassie Buckson				2. DATE AND HOUR OF DEATH 1/13/65 4²⁵ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2601 E. Biddle St.			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-10-1917	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Leeds S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Mayfield				14. MOTHER'S MAIDEN NAME Ella Lyles			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 204-17-260X		17. INFORMANT James Buckson Sr.			
				ADDRESS 2601 E. Biddle St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Chronic myelocytic leukemia type				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/10/17 to 1/13/65 , that (I) (we) last saw the deceased alive on 1/13/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Martin A. Sumners				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/13/65	
23C. PHYSICIAN'S NAME (Type) Martin A. Sumners				23D. ADDRESS Sinai Hosp.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1-16-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK.		24D. LOCATION (City, town, or county) (State) Arbutus Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Randolph Collick			
				ADDRESS 1412 E. Preston			

FUNERAL DIRECTOR: IMPORTANT

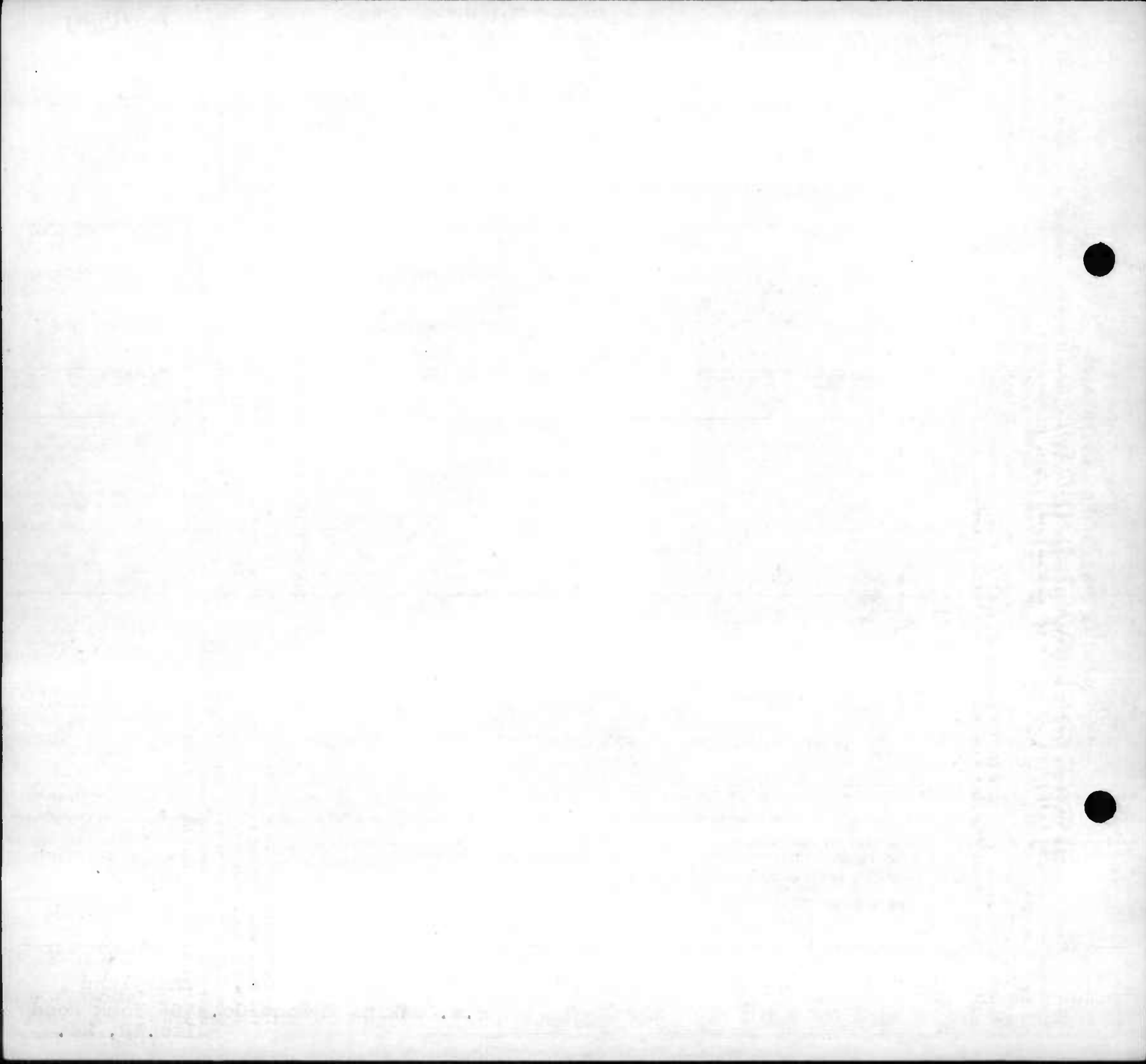
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0579	
BIRTH NO. 65 0579		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DOROTHY V. HORINE	
2. DATE AND HOUR OF DEATH JANUARY 14, 1965 9:02 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) G EAST READ ST.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 9/20/04	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10B. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME NEWTON T. HORINE			
14. MOTHER'S MAIDEN NAME SADIE E. GAVER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 314-40-6407		17. INFORMANT DR. FRED O. SMITH			
18. 204.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Lymphatic Leukemia DUE TO (B) Gastrointestinal Hemorrhage DUE TO GU hemorrhage (C) Intracerebral Hemorrhage			
19. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> N/A Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 7 1965 to JANUARY 14 1965, that (I) (we) last saw the deceased alive on JANUARY 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick O. Smith				23B. DATE SIGNED JANUARY 14, 1965	
23C. PHYSICIAN'S NAME (Type) DR. FREDERICK O. SMITH				23D. ADDRESS UNION MEMORIAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/1965		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cem.	
24D. LOCATION (City, town, or county) (State) Frederick, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No. 65 0580	
BIRTH NO. 65 0580											
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. FREDERICK C. GUTMAN						2. DATE AND HOUR OF DEATH 1/14/65 9:45 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL						A. STATE MARYLAND B. COUNTY Balto.					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL - PARKTON 53-00					
						D. STREET ADDRESS (If rural, give location) MIDDLETOWN RD. #2					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 4/24/81	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT				10B. KIND OF BUSINESS OR INDUSTRY MEAT PACKING		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MR. WILLIAM GUTMAN						14. MOTHER'S MAIDEN NAME MISS ELIZABETH CLUBB					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215 09 9055		17. INFORMANT ADDRESS MRS WALTER L. PRINCE - SAME					
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)											
CAUSE OF DEATH											
INTERVAL BETWEEN ONSET AND DEATH											
(A) CORONARY ARTERY INSUFFICIENCY DUE TO											
(B) ATHEROSCLEROTIC HEART DISEASE DUE TO											
(C)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GANGRENE LEFT FOOT											
19A. DATE OF OPERATION 2 NONE				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/9 1965 to 1/14 1965, that (I) (we) last saw the deceased alive on 1/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE James S. Gregory M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type) JAMES S. GREGORY M.D.								23D. ADDRESS Church Home + Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965				25B. NAME OF REGISTRAR Robert E. Farkley M.D.				25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



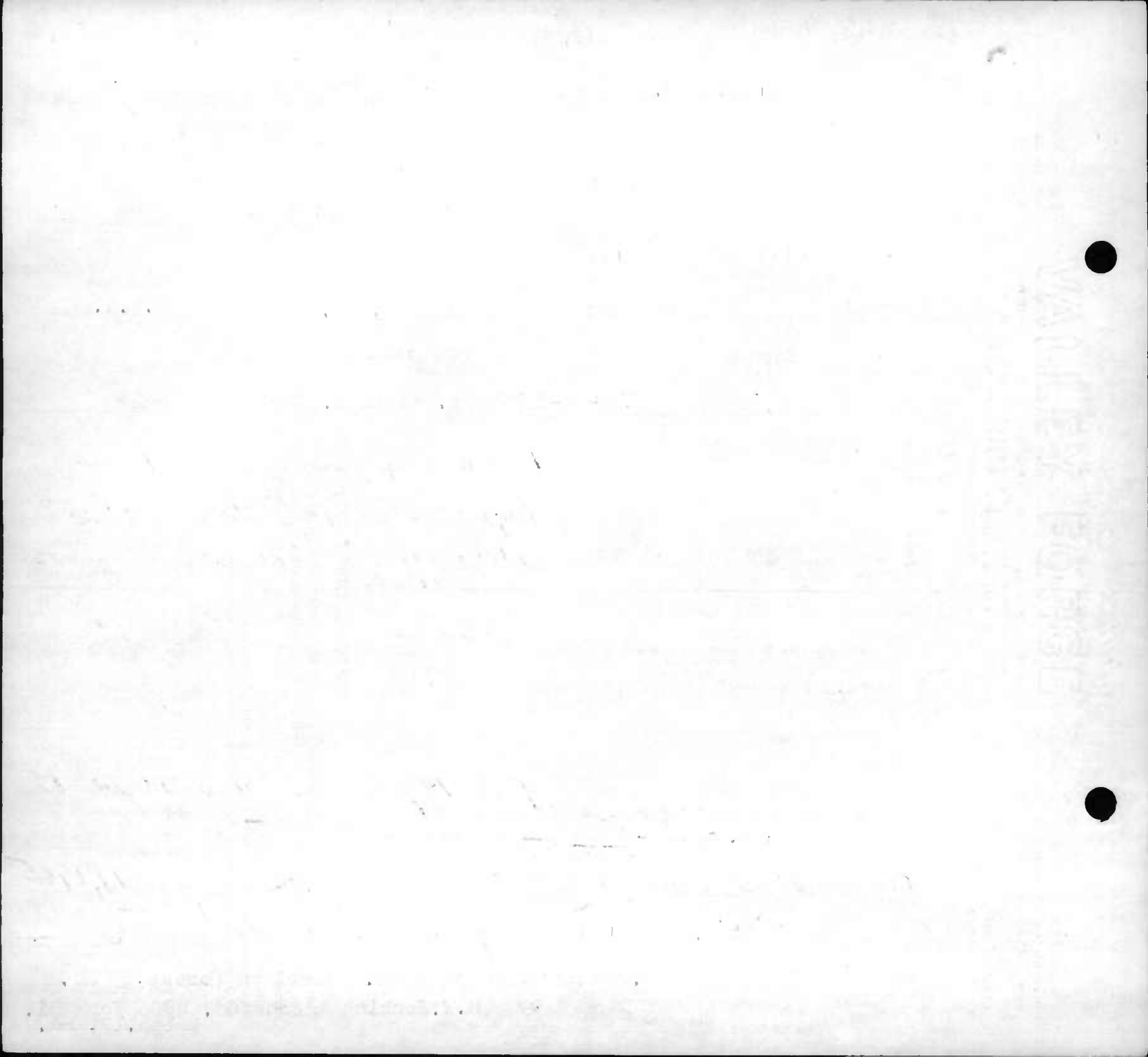
G. 6351

William Gordon

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0581				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0581	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				WILLIAM H. GORDON		1-14-65 4:00PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND		BALTIMORE			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
MALE		WHITE				MARRIED		7-29-08	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)	
Executive				Printing		Richmond, Va.		56	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?			
WALTER Gordon				ROSABELL BRAGG		U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				212-01-2337		Mrs. Amelia C. Gordon		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				18 hrs	
ANTECEDENT CAUSES				(B) DUE TO				24 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO				20 years	
II				None					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2						YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Jan 14 Jan. 1965 to 4pm 14 Jan 1965, that (I) (we) last saw the deceased alive Jan 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						M.D.		23B. DATE SIGNED	
Herbert J. Harwick								Jan. 14, 1965	
23C. PHYSICIAN'S NAME (Type)						M.D.		23D. ADDRESS	
Herbert J. HARWICK								Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				1/16/1965		St. Thomas 'Garrison Frst.		Garrison Forest, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JAN 18 1965				Robert E. Farley, M.D.		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 24-21-32
65 0582

BIRTH NO. 65 0582

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Theresa A. Benjamin

2. DATE AND HOUR OF DEATH

1/14/65 1:20PM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital
Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1029 St. Dunstan Rd. Balt. 12,

5. SEX

F

6. RACE

White

7. MARRIED/NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12-21-22

9. AGE (In years lost birthday)

42

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

house wife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

U.S.A. - Detroit, Mich.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sandor Halkovich

14. MOTHER'S MAIDEN NAME

Matilda Vilagos

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

379-18-6833

17. INFORMANT

Hospital Chart

ADDRESS

18. 204.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

3 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY or Not

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1 19 65 to Jan 14 19 65, that (I) (we) last saw the deceased alive on Jan 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry H. Bohlman

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/14/65

23C. PHYSICIAN'S NAME (Type)

Henry H. Bohlman

University Hosp.

M.D.

23D. ADDRESS

22 S. Greene St.
Baltimore 1, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/16/1965

24C. NAME OF CEMETERY or CREMATORY

Dulaney Valley Mem. Grds. Cockeysville, Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

25B. NAME OF REGISTRAR

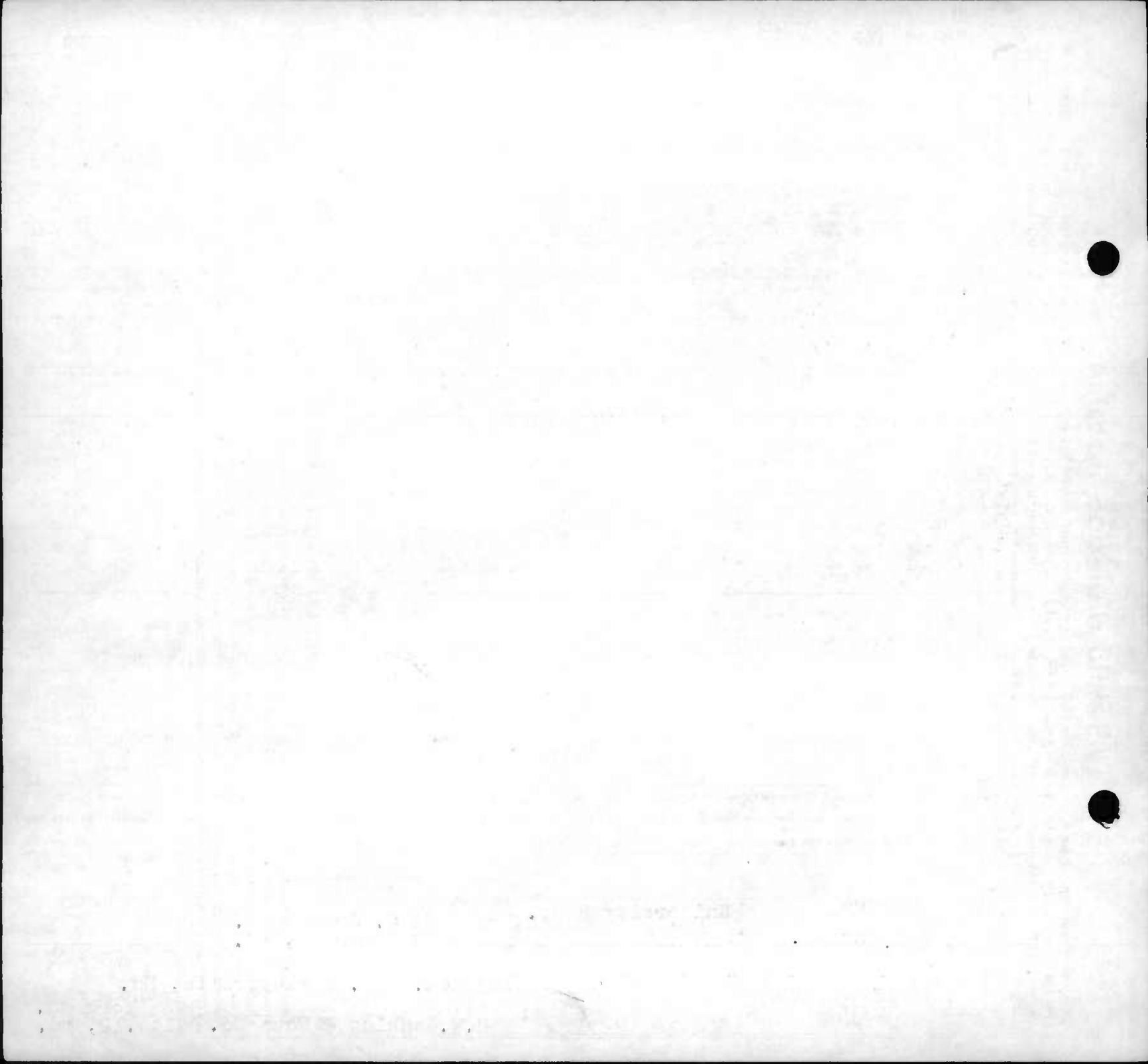
Robert E. Bailey M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. Balto. 12, Md.

ADDRESS

4905 York Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0583		CRESCENZO		CERTIFICATE OF DEATH		Registered No. 65 0583	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Rose Crescenzo				1-16-65 4 ³⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
UNION MEMORIAL HOSPITAL				Maryland		Balts.	
5. SEX F				6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
HOUSEWIFE		-		10-8-92		72	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
New York City				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DOMINIC FATTUROS				Louisa Petchell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
-		113-51-9814		chart - Union Memorial Hospital			
18. 420.11				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) MYOCARDIAL INFARCTION 23 days			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) ARTERIOSCLEROTIC Cardiovascular Years			
ANTECEDENT CAUSES				(C) Pleural Effusion left 2 weeks			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(D) Atrial fibrillation 3 weeks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (A) (this hospital) attended the deceased from 12-22 19 64 to 1-16- 19 65 , that (B) (we) last saw the deceased alive on 1-16- 19 65 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Lawrence J. Lieberman						1-16-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LAWRENCE J. LIEBERMAN				Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1-19-65		CALVARY CEMETERY		LONG ISLAND CITY N.Y.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 18 1965		Robert E. Farley M.D.		HENRY W. JENKINS SONS CO.		4905 YORK RD BALTO, MD	

R 540

65 0584

BALTIMORE CITY HEALTH DEPARTMENT

65 0584

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59315

1. NAME OF DECEASED
(Type or Print)

NORMALEE B. RUMMEL

2. DATE AND HOUR PRONOUNCED DEAD

January 13, 1965 2:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

500 E. 34th Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/24/1917

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Radio Production

10B. KIND OF BUSINESS OR INDUSTRY

Bendix Corp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eugene Harrison

14. MOTHER'S MAIDEN NAME

Beatrice Caulk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-03-3686 Jack O. Rummel

17. INFORMANT

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Chronic Alcoholism.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Charles S. Petty, M.D.
Charles S. Petty, M.D.CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/18/1965

23C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

23D. LOCATION (City, town, or county)

Baltimore County,

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Road
Baltimore 12, Md.

ADDRESS

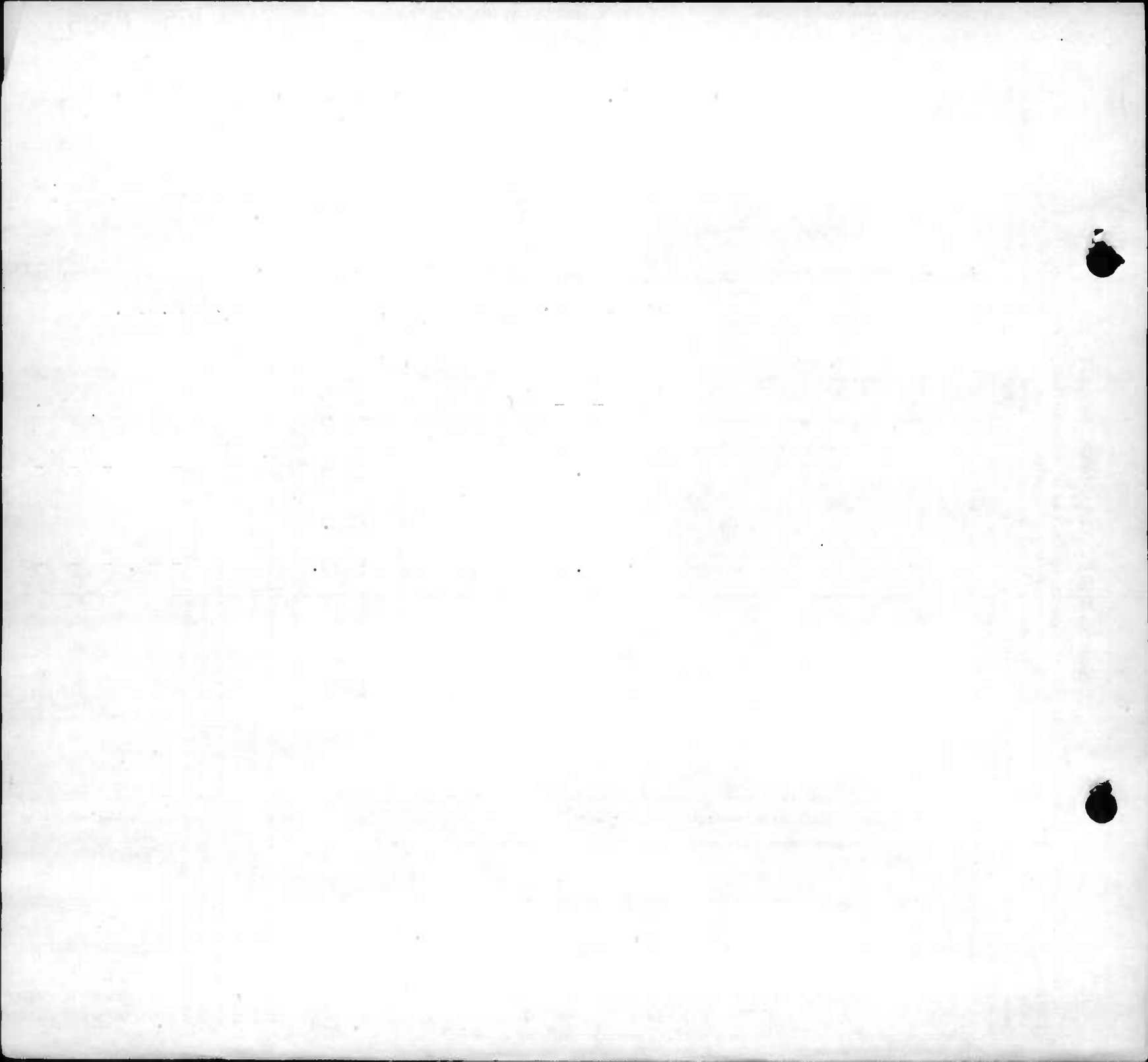
WALTER JONES

WALTER JONES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

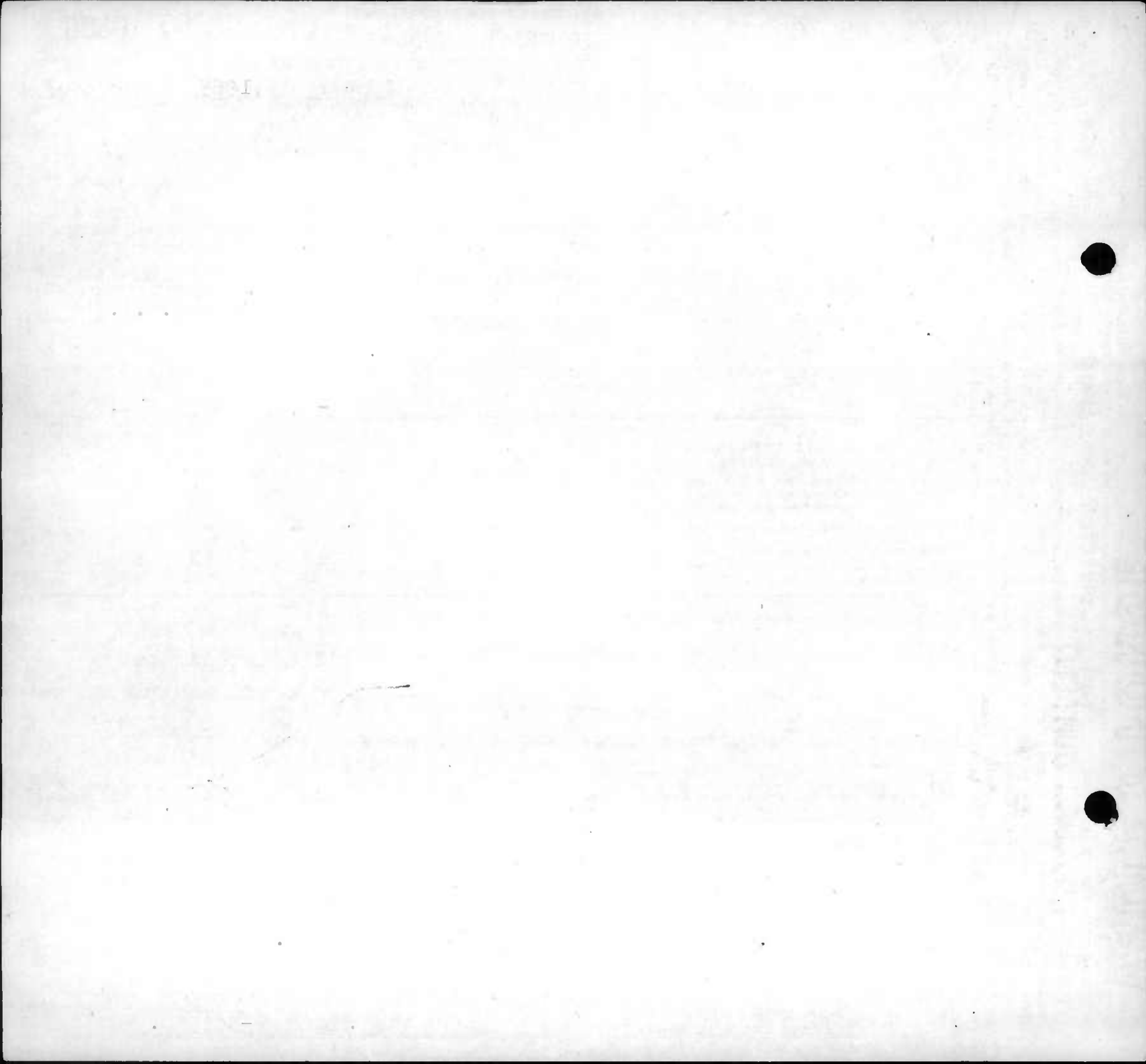
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0585	
BIRTH NO. 65 0585				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Jackson, Leroy T. Sr			January 13, 1965 4:10a M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1918 Druid Hill Ave.		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-16-01	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Processor Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Jackson, Thomas			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Turner, Matilda			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 219-22-5540			17. INFORMANT ADDRESS Eva Jackson-wife 1918 Druid Hill Ave.		
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
			1. (A) Carcinoma of right left Lobe of lung with metastasis to regional lymphnode and liver. DUE TO 1-6-65 - 1-13-65		
			2. (C) Pulmonary congestion. DUE TO 1-6-65 - 1-13-65		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1-6- 19 65 to 1-13-65 19 65 , that (I) (we) last saw the deceased alive on 1-13-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gilbert Banfield				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type or Print) Gilbert Banfield				23D. ADDRESS M.D. 722 N. Fulton Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/16/65		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery	
24D. LOCATION Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Herbert E. Mutter			
25D. ADDRESS 3035 W. North Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0586	
BIRTH NO. 65 0586							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Sallie Belle Truesdale				2. DATE AND HOUR OF DEATH January 15, 1965 3:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 15-37	
3137 Artaban Place				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3137 Artaban Place			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/31/1886	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Camden South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace Reynolds				14. MOTHER'S MAIDEN NAME Mazerine McCray			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mazie Aaron -3137 Artaban Pl.		ADDRESS	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Hypertensive Heart Disease DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH Seven years	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/30 1959 to 1/15 1965 , that (I) (we) last saw the deceased alive on 1/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) did (did not) view the body after death.							
23A. SIGNATURE Emerson R. Julian				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) Emerson R. Julian				23D. ADDRESS M.D. 2329 Arunah Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/1965		24C. NAME OF CEMETERY or CREMATORY Camden Cemetery		24D. LOCATION (City, town, or county) (State) Camden South Carolina	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS -3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0587

BIRTH NO. 65 0587

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Schmitz, Emma N.

2. DATE AND HOUR OF DEATH

January 16, 1965 9:08 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

9-01

5. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 18

6. STREET ADDRESS (If rural, give location)

4126 The Alameda

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

8/28/96

9. AGE (In years last birthday)

68

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John J. Noonan

14. MOTHER'S MAIDEN NAME

Emma P. Mc Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. E. John Schmitz, Jr. 1920 Woodbourn

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 13, 1965 to January 16, 1965, that (I) (we) lost saw the deceased alive on January 16, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Yim. Pill SUN

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

January 16, 1965

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/20/65

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Rd.

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0588

BIRTH NO. 65 0588

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George E. Groth

2. DATE AND HOUR OF DEATH

January 15, 1965. 11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

4638 Harcourt Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore # 14

D. STREET ADDRESS (If rural, give location)

4638 Harcourt Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-28-1913

9. AGE (in years
last birthday)

51

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Production Planer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George E. Groth, Sr.

14. MOTHER'S MAIDEN NAME

Elsie I. Gelston

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217038956

17. INFORMANT

Mrs. Leona C. Groth

ADDRESS

Same

18.

163X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

CA OF LONG 5/1964

Severe Pulmonary Fibrosis 1963

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/14/65 1963 to 1/15/65 1965 that (I) (we) last saw the deceased alive on 1/14/65 1963 and that in (my) (our) opinion death occurred on the date 1/15/65 11:45 AM 1965 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Walter E. Karfgin

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1/15/65

23C. PHYSICIAN'S NAME (Type)

Walter E. Karfgin

23D. ADDRESS

4331 Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/18/65

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

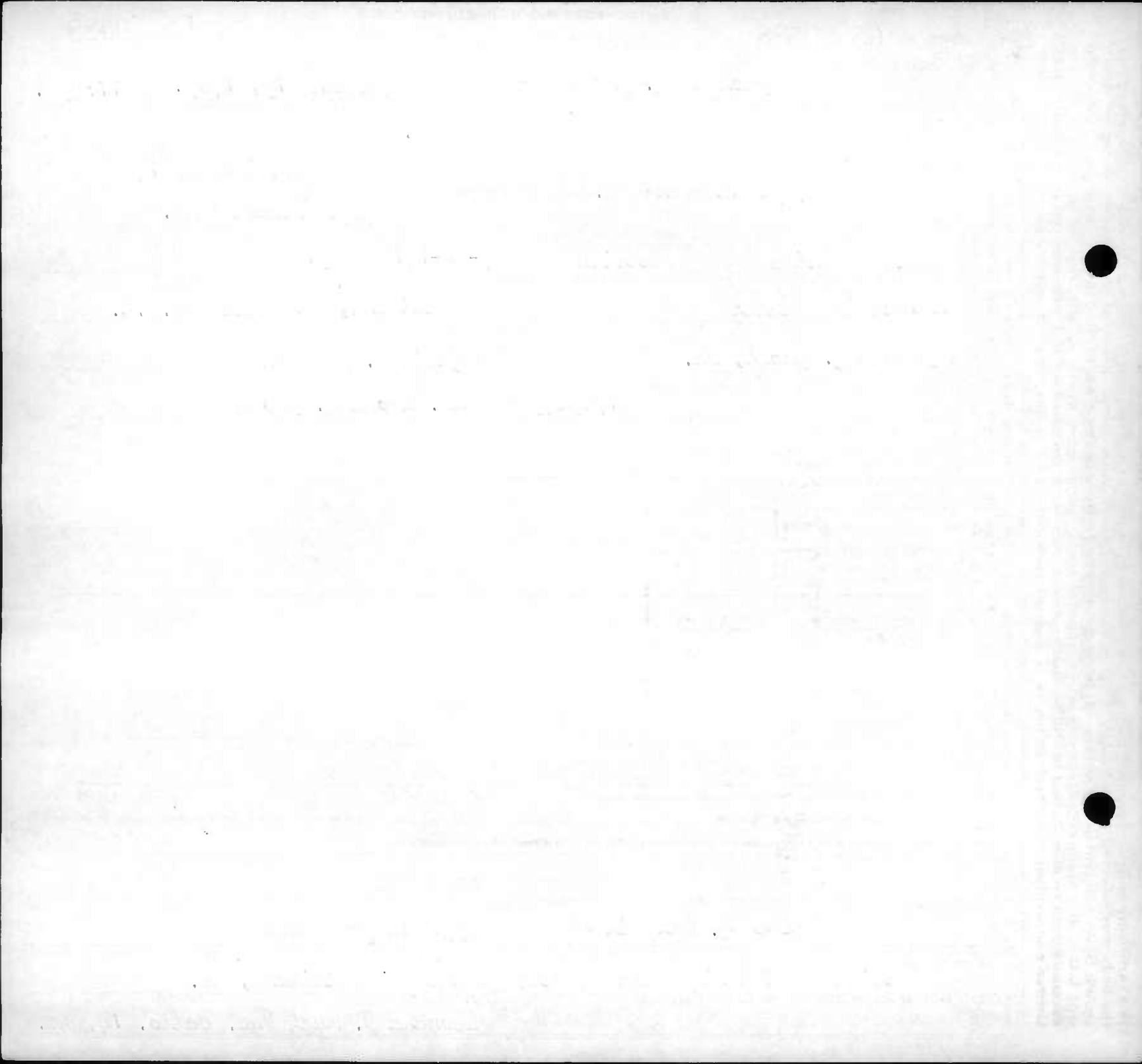
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. 14, Md.

ADDRESS



B-562-1

65-01326

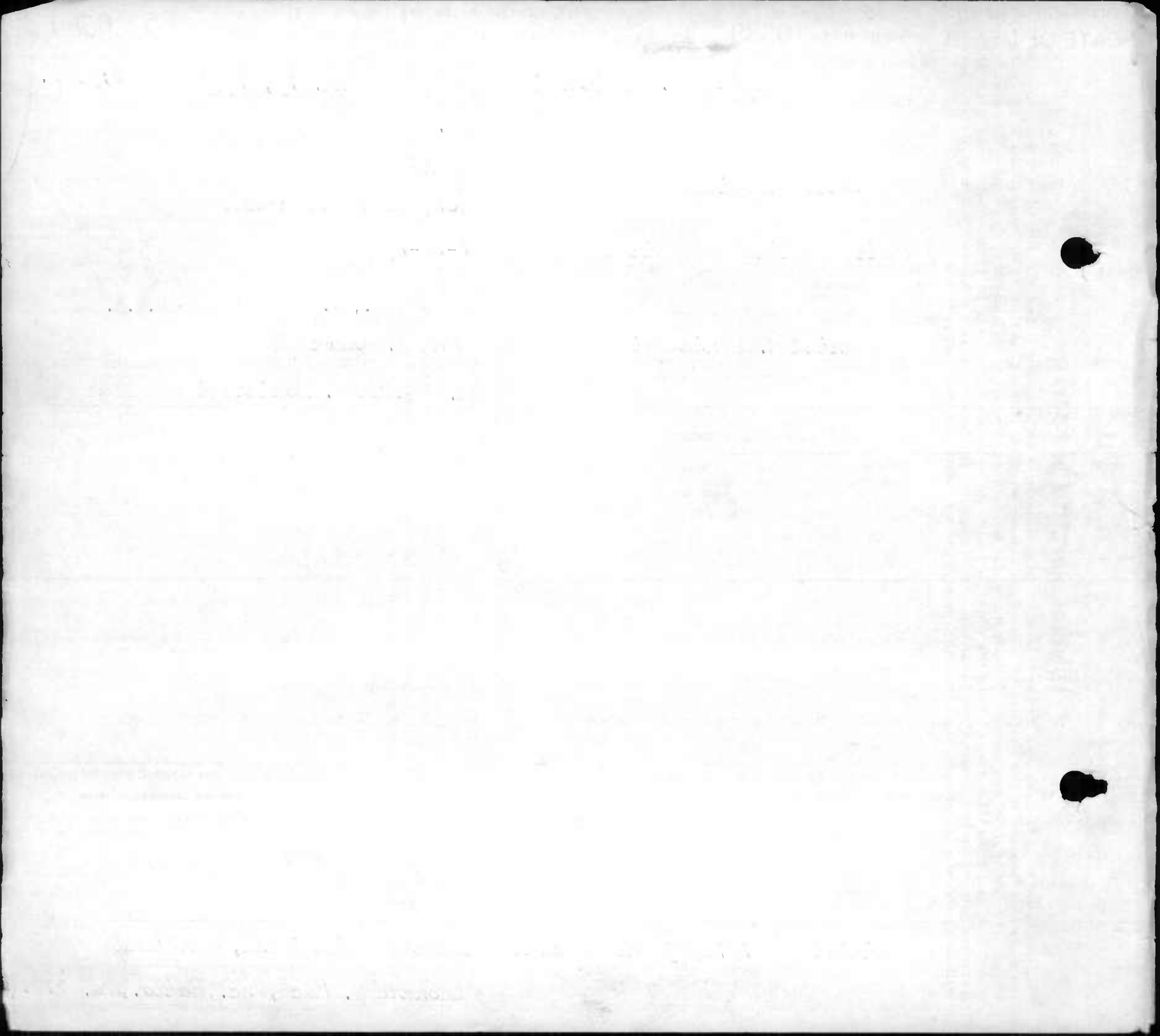
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0589

BIRTH NO. 65 0589		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Jeffery D. Boniarski</i>		2. DATE AND HOUR OF DEATH <i>Jan. 15, 1965 6:50 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-06</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2814 Echodale Avenue</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>1-10-1965</i>
9. AGE (In years last birthday) <i>5</i>		10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>BALTO., MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel A. Boniarski</i>		14. MOTHER'S MAIDEN NAME <i>Ann S. Krawczyk</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Daniel A. Boniarski</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, atherio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>CONGESTIVE HEART FAILURE</i> DUE TO (B) <i>CONGENITAL HEART DISEASE</i> DUE TO <i>(SINGLE VENTRICLE & persistent TRUNCUS ARTERIOSUS)</i> (C) INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 10 1965</i> to <i>Jan. 15 1965</i> . that (I) (we) lost saw the deceased alive on <i>Jan. 15 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Smeldon B. Salario</i>		23B. DATE SIGNED <i>1/16/65</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Mercy Hospital, Balto., Md. 21202</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1/16/65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>	25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md. 21214</i>	

FUNERAL DIRECTOR: IMPORTANT

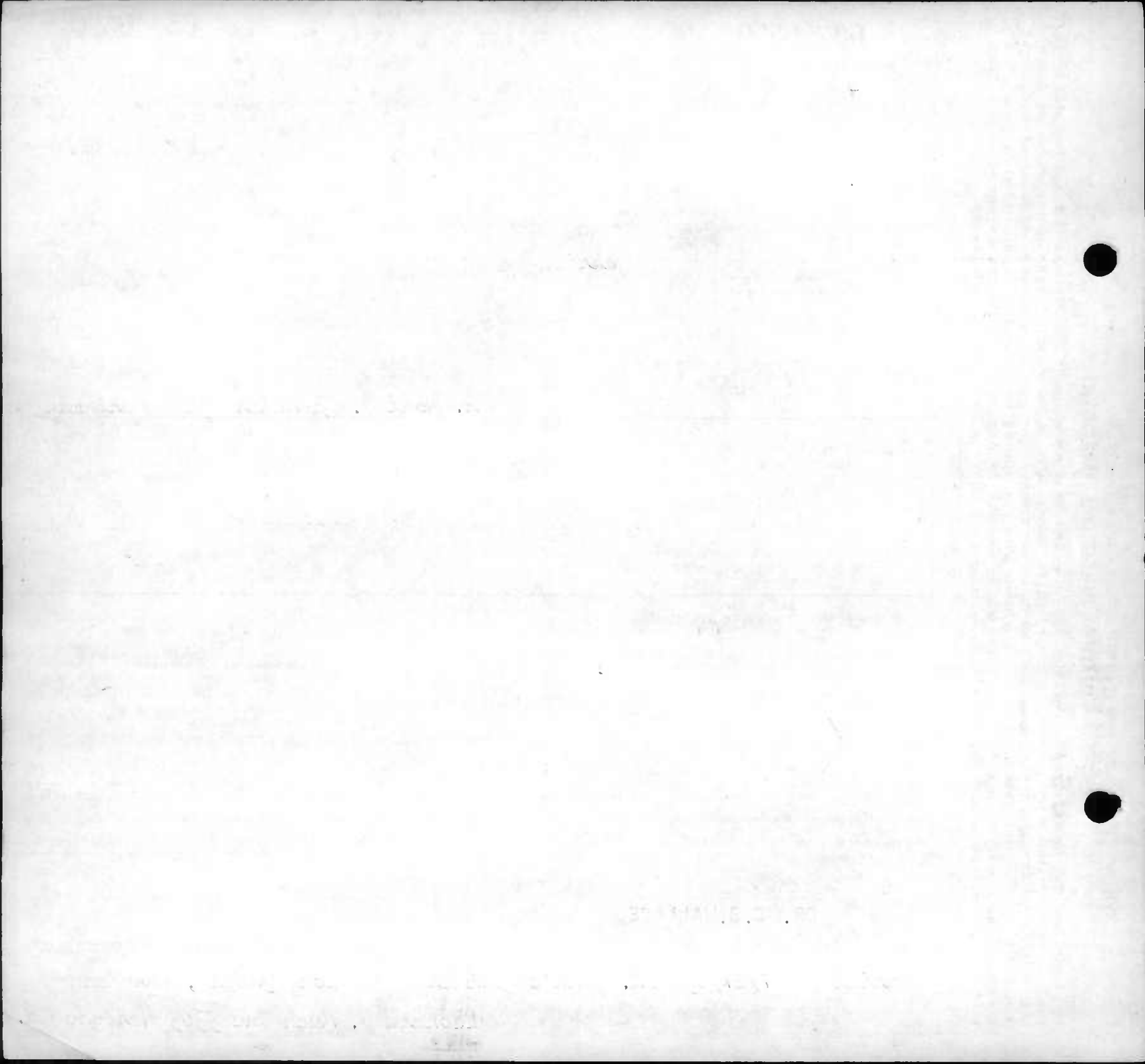
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

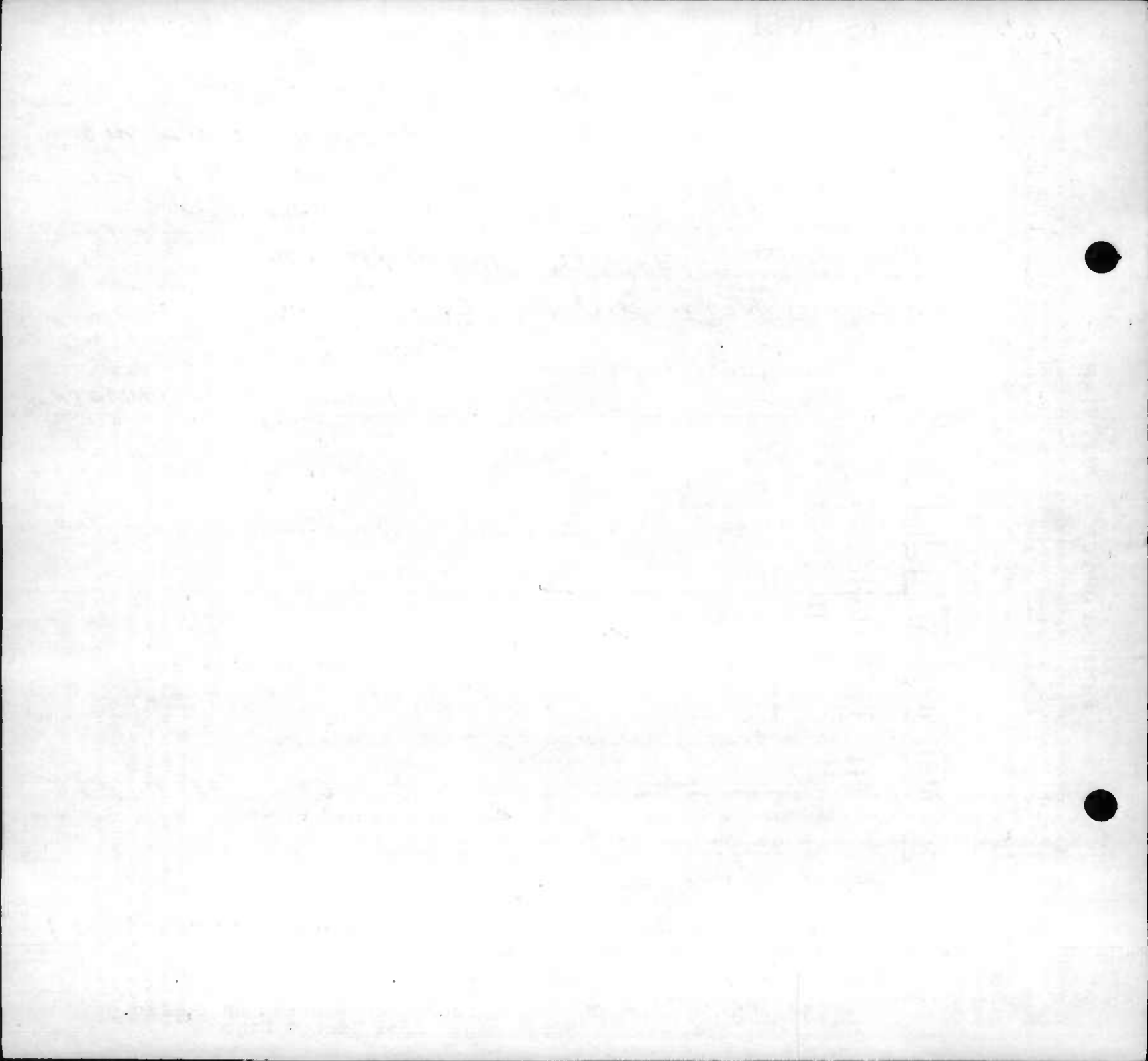
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0590				
BIRTH NO. 65 0590									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) ANN ELIZABETH CHANDLER					2. DATE AND HOUR OF DEATH 1/18/65 1:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 27-05				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3230 Northway Dr.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10/29/35	9. AGE (In years last birthday) 29	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Livingston					14. MOTHER'S MAIDEN NAME Alice Lacey				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Noel J. Chandler			ADDRESS 3230 Northway Dr.	
18. 5720 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Stomach Regional Enteritis DUE TO intestinal obstruction & extra abdominal abscess (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/16 1964 to 1/18 1965, that (I) (we) last saw the deceased alive on 1/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE C.B. Wallace					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) DR. C. B. WALLACE ANDERSON RENICK					23D. ADDRESS % Union Memorial Bldg				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/21/65		24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) (State) Long Green, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			25B. NAME OF REGISTRAR Robert E. Taylor M.D.			25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0591 M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 0591	
1. NAME OF DECEASED (Type or Print) PETER J. KELLY			2. DATE AND HOUR OF DEATH JAN 15 1965 950A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1421 WALKER AVE BALTO. 21212 MD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY MD C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD 27-38 D. STREET ADDRESS (If rural, give location) 1421 WALKER AVE		
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Aug. 19 1888	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ICE BUSINESS RETIRED SELF EMPLOY.		10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE MD		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
13. FATHER'S NAME Thomas J. Kelly			14. MOTHER'S MAIDEN NAME JENNY HEANING		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 216 32 5779		17. INFORMANT MRS Mildred Rohm 1421 WALKER AVE	
18. 350X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) PARKINSON'S DISEASE DUE TO (B) ACUTE Viral Infection DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs 72 Hours		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) - NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 1/12/65 to 1/15/65 that (I) (we) last saw the deceased alive on 1/14/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ferd. E. Kadan M.D.				23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) FERD. E. KADAN			23D. ADDRESS 5820 YORK ROAD (21212)		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/65		24C. NAME OF CEMETERY or CREMATORY Bohemian National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			
25D. ADDRESS 3331 Brehms Lane		25E. ADDRESS			



1
5.300

65 0592

BALTIMORE CITY HEALTH DEPARTMENT

65 0592

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59330

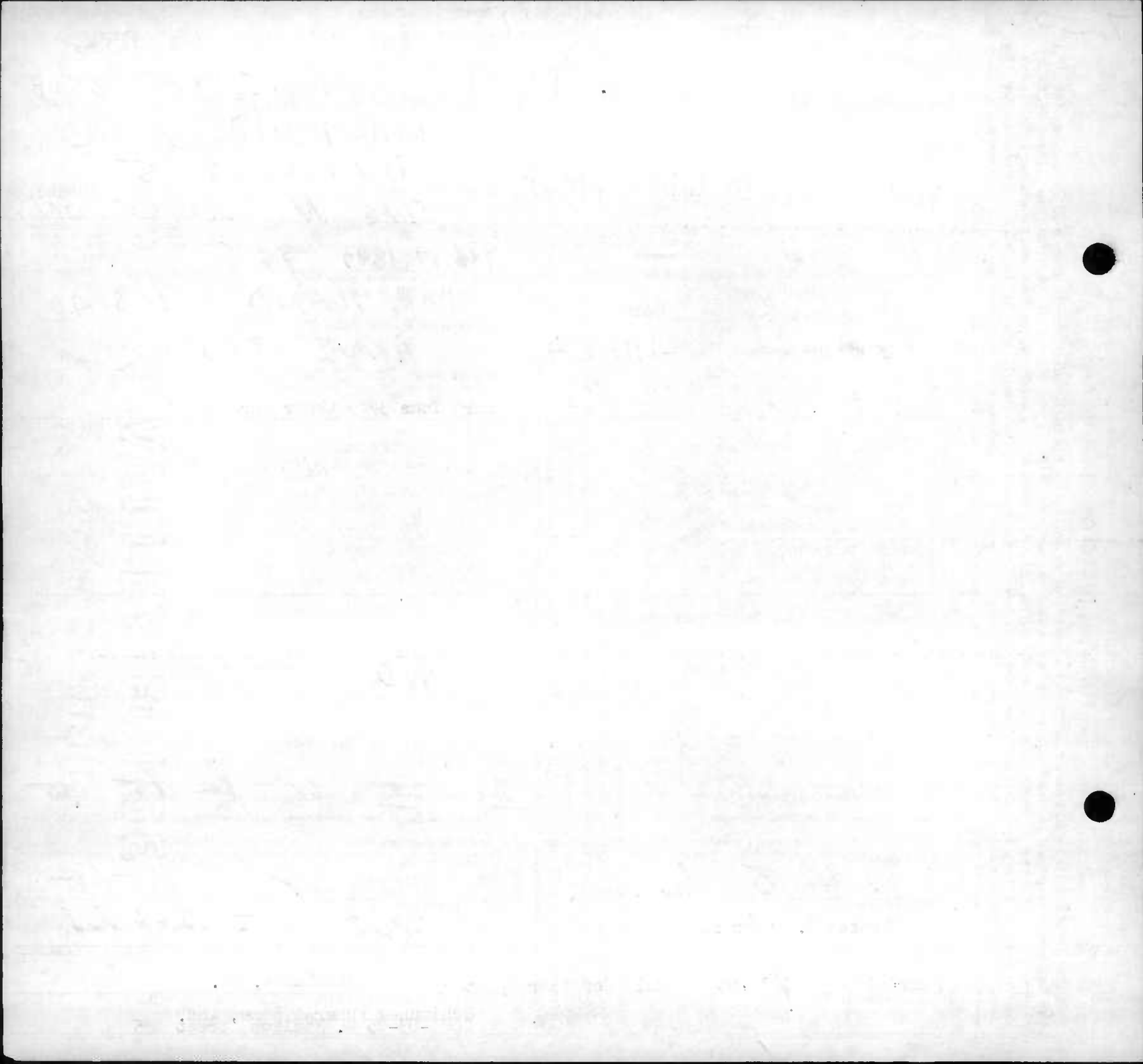
1. NAME OF DECEASED (Type or Print) Ethel B. Shutt				2. DATE AND HOUR PRONOUNCED DEAD Jan. 15, 1965 1:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2705 D. STREET ADDRESS (If rural, give location) 3114 Royston Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH April 22, 1885	9. AGE (In years last birthday) 79	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jas Reynolds				14. MOTHER'S MAIDEN NAME ALICE TILLMAN.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT DAUGHTER		ADDRESS Same	
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Hypertensive and arteriosclerotic cardiovascular disease DUE TO (B) DUE TO (C) DUE TO			
				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John E. Adams M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Jan. 16, 1965							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 1/18/65		23C. NAME OF CEMETERY or CREMATORY WOODLAWN		23D. LOCATION (City, town, or county) (State) BALTO CO.	
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR P.A. Heermann		ADDRESS 6067 HARFORD RD.	

WATLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

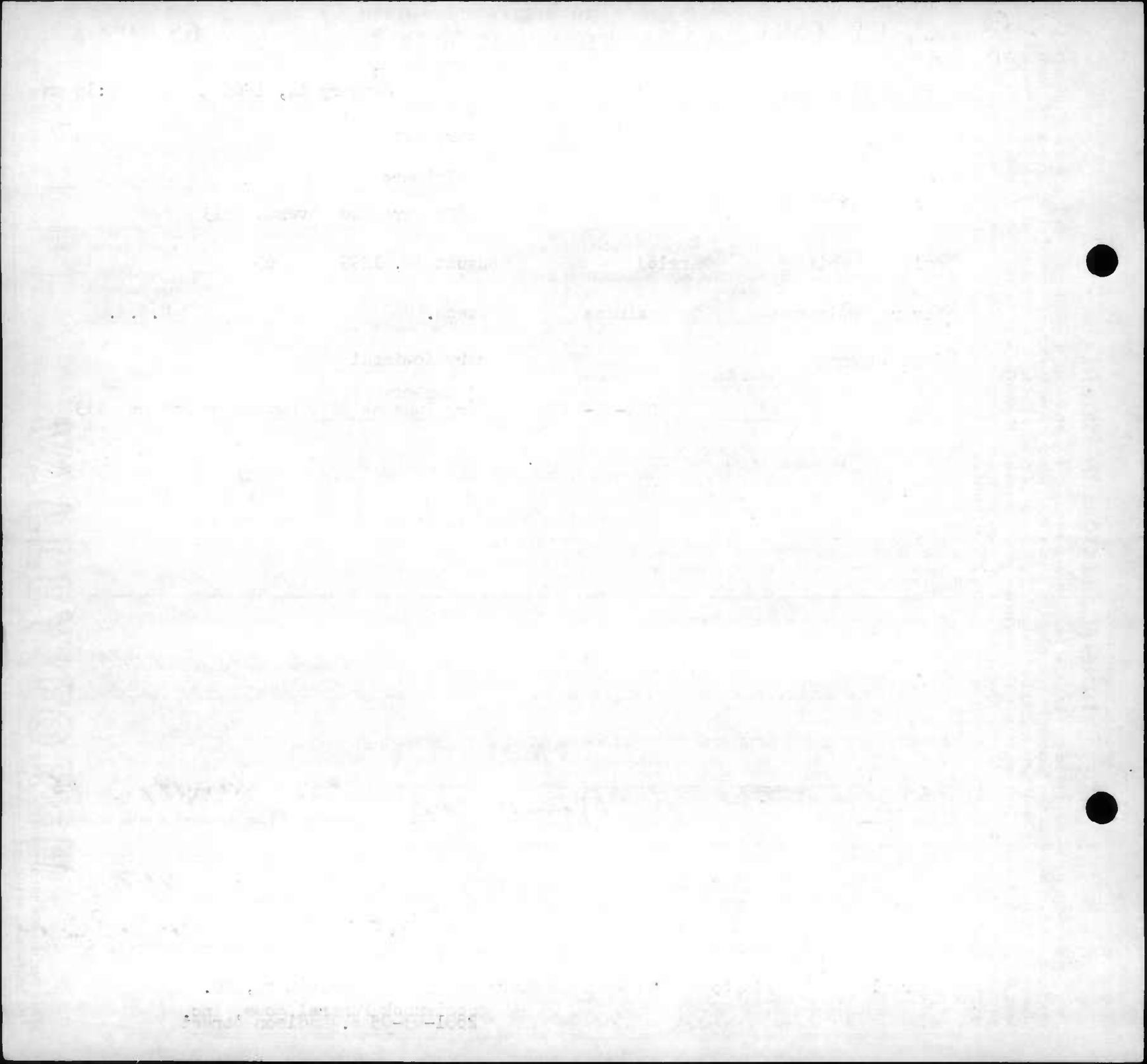
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0593	
BIRTH NO. 65 0593		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BARBARA A. TJMA		2. DATE AND HOUR OF DEATH JAN. 15 1965 6:30 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) MONTERBELLO STATE HOSP		A. STATE MARYLAND B. COUNTY 7-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5	
		D. STREET ADDRESS (If rural, give location) 945 N. COLLINGTON		Avenue	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH Feb. 7, 1889	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WENCESLAUS HYLKA		14. MOTHER'S MAIDEN NAME ANNE BRUSAK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Not known		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Earl Tuma 3803 Cedar Hurst Road #6	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF BREAST.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NEO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 28 1964 to Jan 15 1965 , that (I) (we) last saw the deceased alive on Jan 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reuben C. Guerrero		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) Reuben C. Guerrero		23D. ADDRESS Montebello State Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Sisk		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street #5	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0594	
BIRTH NO. 65 0594				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FRANK YUHANAK			2. DATE AND HOUR OF DEATH January 14, 1965 6:15 am		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3829 Ravenwood Avenue #13			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2603 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3829 Ravenwood Avenue #13		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH August 10, 1899	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Business		10B. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Czech.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Yuhanak			14. MOTHER'S MAIDEN NAME Mary Kominski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-7573	17. INFORMANT ADDRESS (Nee Gonda) Mary Yuhanak 3829 Ravenwood Avenue #13		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinoma - Lung DUE TO (B) Cerebral-arteriosclerosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 yrs - ?
			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1962 to Jan. 14 1965 , that (I) (last) last saw the deceased alive on Jan 12 1965 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis F. Klimes			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/15/65
23C. PHYSICIAN'S NAME (Type) LOUIS F. KLIMES			23D. ADDRESS M.D. 2623 E. Monument St. Balt 5 Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/16/65	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Schimmek Funeral Home Inc. 2891-03-05 E. Madison Street	

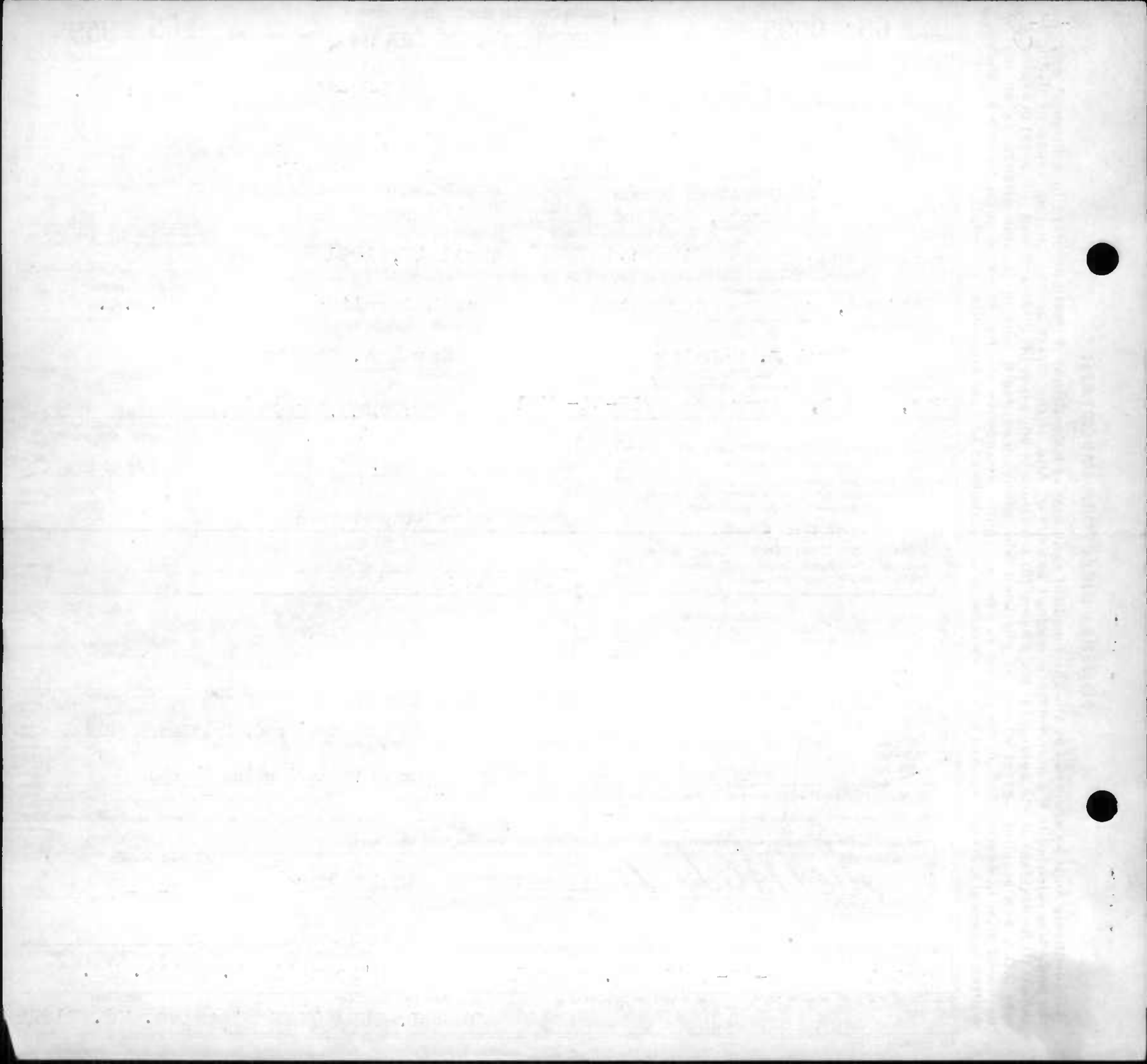


AB 42-61-43
M 4-01-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

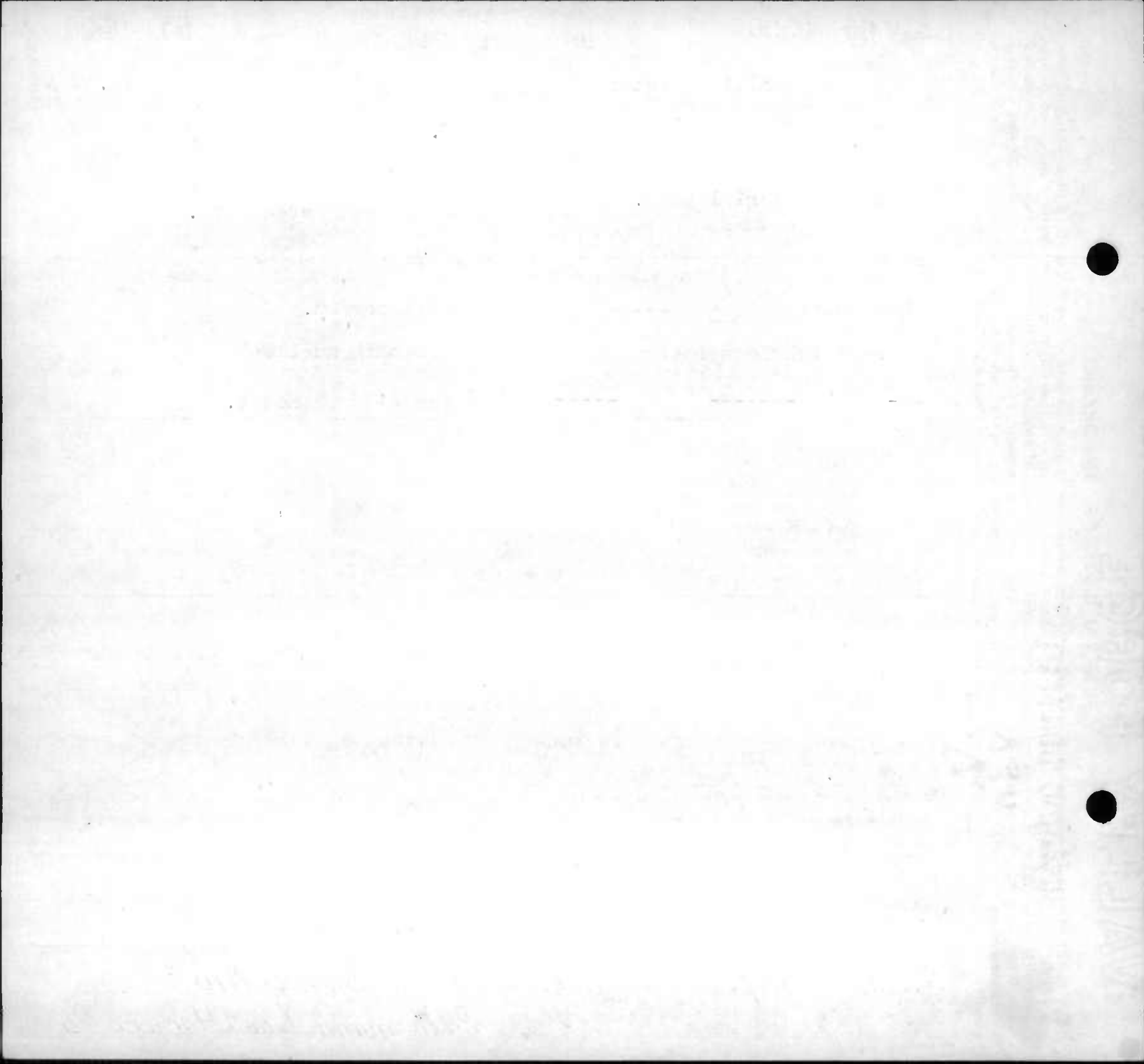
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0595	
BIRTH NO. 65 0595				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles Mahaley Sr.				1-16-65 3:05 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				A. STATE B. COUNTY Maryland, Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural Dundalk 53-00	
				D. STREET ADDRESS (If rural, give location) 215 Parkwood Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH April 17, 1891	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired,
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired,			10B. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) North Carolina
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul E. Mahaley
13. FATHER'S NAME Paul E. Mahaley			14. MOTHER'S MAIDEN NAME Sarah A. Barnes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes, WW I, Army
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes, WW I, Army			16. SOCIAL SECURITY NO. 215-01-0721		17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Severe Fluid Loss Burns 80% of Body Surface		INTERVAL BETWEEN ONSET AND DEATH 17 1/2 Hours
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 215 Parkwood Road, Baltimore #21222
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Burned while smoking in bed
22. I certify that (I) (this hospital) attended the deceased from 1-15 1965 to 1-16 1965, that (I) (we) last saw the deceased alive on 1-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Don Alexander				23B. DATE SIGNED 1-16-65	
23C. PHYSICIAN'S NAME (Type) Dr. Don Alexander				23D. ADDRESS 4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan-19-1965		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel	
24D. LOCATION O'Donnell St. Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR JOHN J. DUDA		25D. ADDRESS 7922 Wise Ave. Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0596				
BIRTH NO. 65 0596									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Mollie Forster					2. DATE AND HOUR OF DEATH 1/16/65 12.10 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.					A. STATE Md.				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 4305 Loch Raven Blvd.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 6/18/72	9. AGE (In years last birthday) 92	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Bohnenberg					14. MOTHER'S MAIDEN NAME Elizebeth Mueller				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---			16. SOCIAL SECURITY NO. -----		17. INFORMANT Records			ADDRESS Hospt.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostheria, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH ASHD			INTERVAL BETWEEN ONSET AND DEATH	
					(A) DUE TO				
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1/11 19 65 to 1/16 19 65 , that (I) (we) last saw the deceased alive on 1/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/18/65		24C. NAME OF CEMETERY or CREMATORY IMMANUEL CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR P.A. Heemann			ADDRESS 6667 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0597	
BIRTH NO. 65 0597		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John J. P. Holley		2. DATE AND HOUR OF DEATH January 14, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 2-26-65 FILL IN NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-01			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 7/29/1891	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lift Operator & Oiler		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Holley				14. MOTHER'S MAIDEN NAME Isma--Gons-- Anne Clarke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-2560		17. INFORMANT ADDRESS Adelaide Hornick 1433 Lowman St.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				CAUSE OF DEATH (A) DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 to 2 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/11/63 to 11/4/65 that (I) (we) last saw the deceased alive on 10/8 19 64 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Dr. J. S. Ellison							
23A. SIGNATURE E. S. Ellison				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type) E. S. Ellison				23D. ADDRESS M.D. 107 E. West St. #30			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles L. Stevens		ADDRESS Stevens Funeral Home, Inc. 1501 E. Fort Ave.	

V.S. 153

2-26-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0598	
BIRTH NO. 65 0598				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles C. Rettberg			
2. DATE AND HOUR OF DEATH January 17, 1965 4:15 a.m.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-02			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4700 Harford Road Harford Gardens Convalescent Home Baltimore, Maryland 21214		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 101 West Monument Street 21201			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1879 1/26/1965	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chief Clerk		10B. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Rettberg			
14. MOTHER'S MAIDEN NAME Mary Dollinger		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			
16. SOCIAL SECURITY NO. 40 451 49 RR		17. INFORMANT Mrs. James C. Lincoln 350 Paddington Rd. Baltimore, Md. 12			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Bronchopneumonia, bilateral primary DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II ① Cerebral Thrombosis ② Arterio-sclerosis, generalized ③ Gastric ulcer 2 1/2 years.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 26, 1962 to January 15, 1965 . that (I) was last saw the deceased alive on January 15, 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE Gilbert E. Rudman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) GILBERT E. RUDMAN		23D. ADDRESS 2517 W. BALTO. ST., BALTO. 23, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/1965		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Jarboe M.D.		25C. FUNERAL DIRECTOR Wm. J. Jarboe & Sons Baltimore, Md. 21217 North L. Pa. Avenue			

V.S. 153

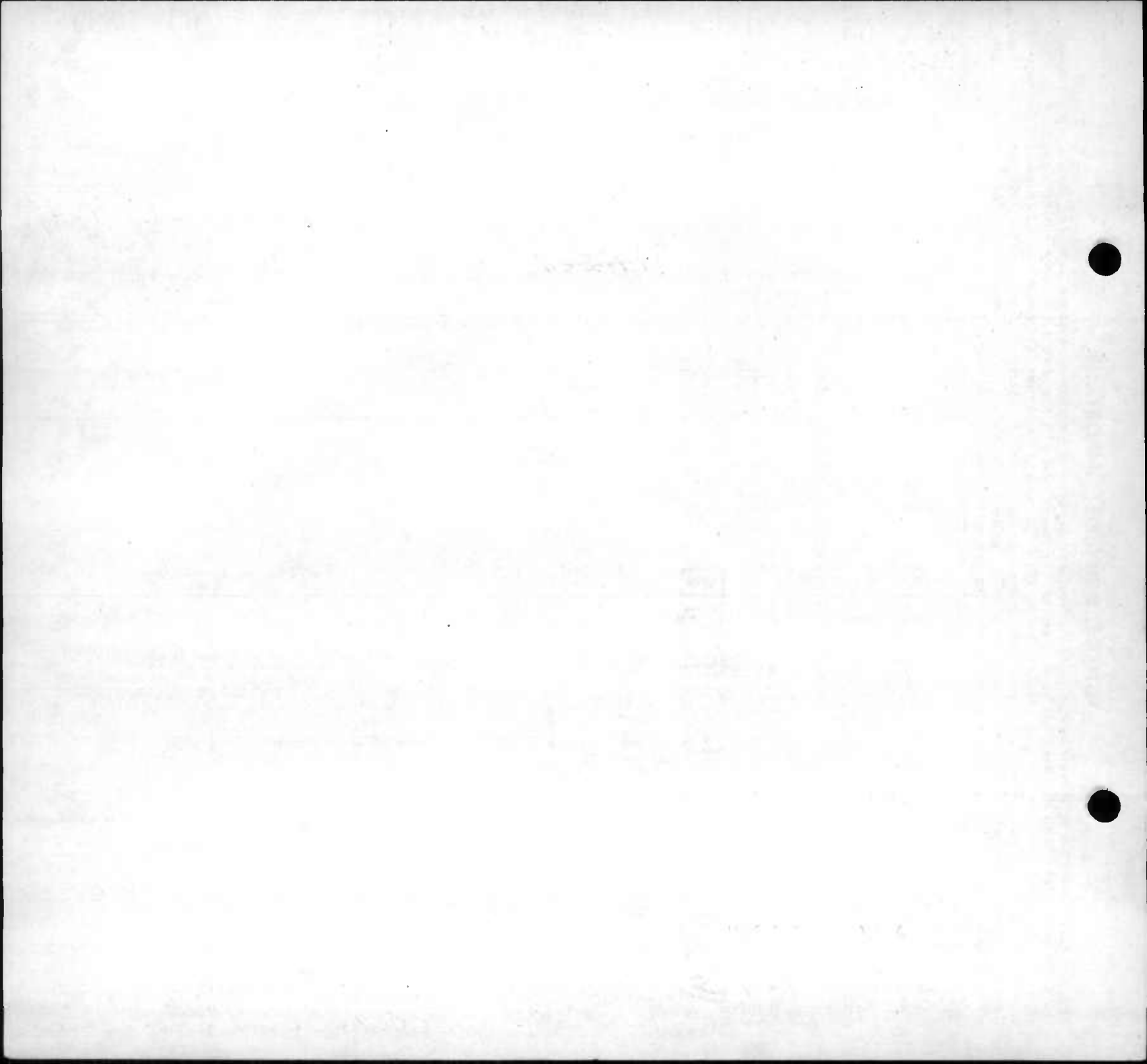
1-25-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

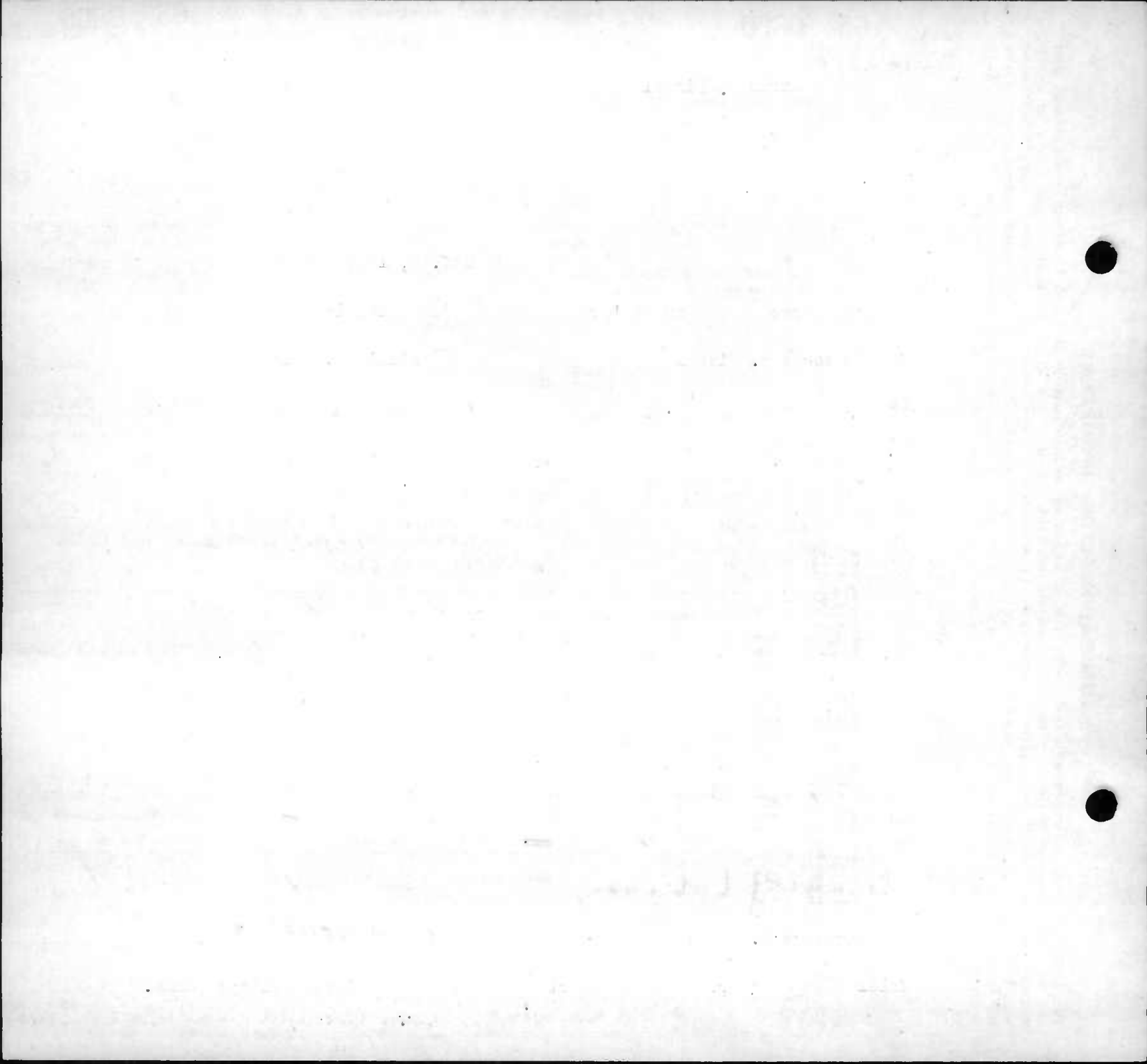
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0599	
BIRTH NO. 65 0599							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Mrs Helen ^{alice} Wirsing				2. DATE AND HOUR OF DEATH January 15, 1965 11 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 12-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) Broadview 116 W. University Parkway			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 4-6-91	9. AGE (In years last birthday) 73	10. If Under 1 yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. GETTIER				14. MOTHER'S MAIDEN NAME IDA FISHER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 212-18-3215		17. INFORMANT UMH CHART		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Generalized arteriosclerosis, vascular				CAUSE OF DEATH (A) DUE TO Bilateral confluent bronchopneumonia & heart pleural effusion (B) DUE TO Carcinoma of the cecum & partial intestinal obstruction. (C)		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/11/1965 to 11/15/1965, that (I) (we) lost saw the deceased alive on 11/15/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Laird Bryson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) A. LAIRD BRYSON				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Wm. J. Dickman & Sons		ADDRESS Baltimore, Md. 21214 North 2 P.A. Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

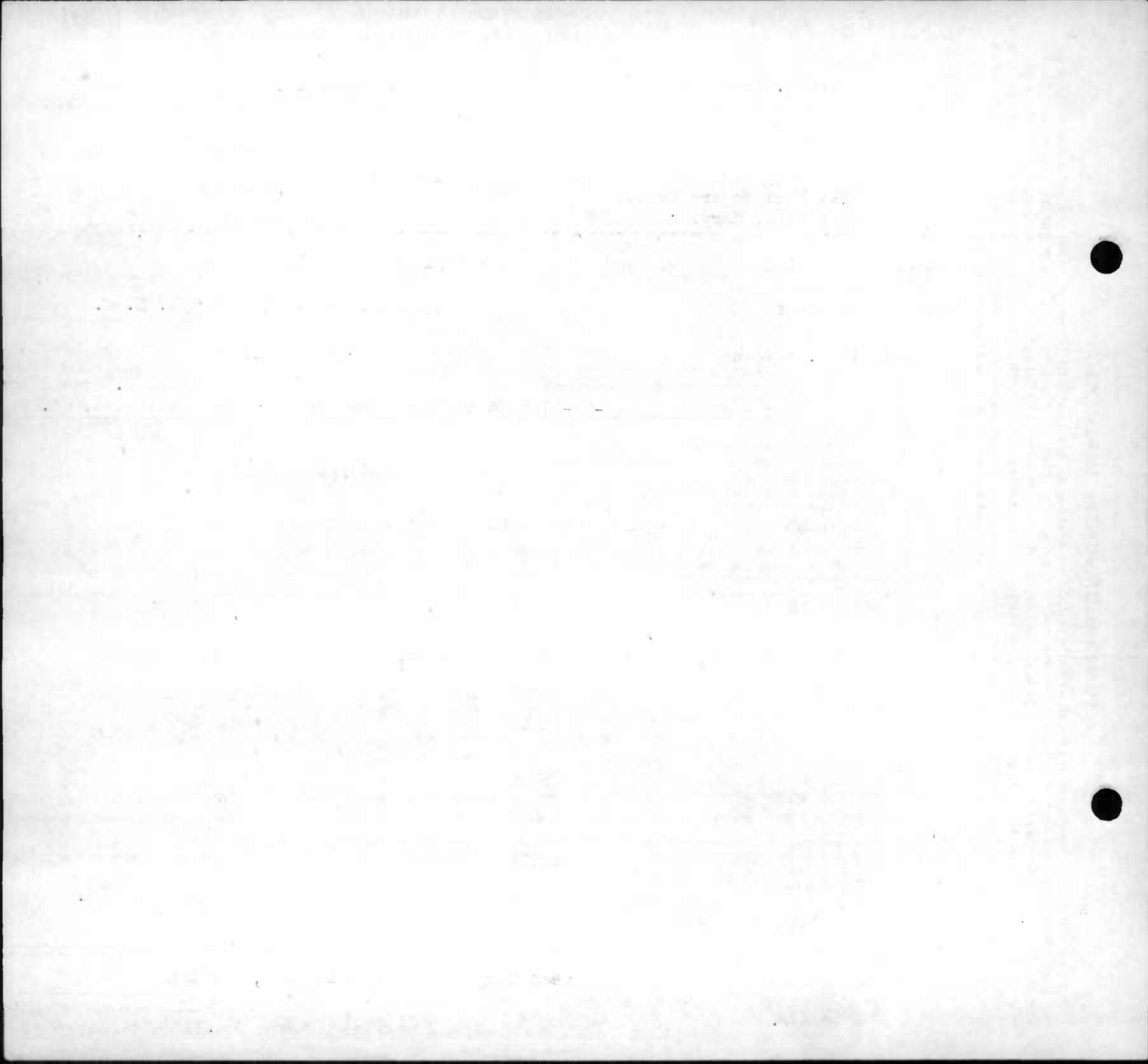
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.		
65 0600		65 0600		65 0600		
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		
				(Type or Print) Marie H. Fishel		
2. DATE AND HOUR OF DEATH		1-16-65 7:40 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND				
		B. COUNTY BALTIMORE				
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
		D. STREET ADDRESS (If rural, give location) 1525 PENTRIDGE RD.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH Oct. 5, 1897	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse	
		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George H. Fishel	
		14. MOTHER'S MAIDEN NAME Lillie M. Nole	15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
		16. SOCIAL SECURITY NO. -	17. INFORMANT Chart-Union Memorial Hospital			
		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Cardiac Tamponade due to rupture of the ascending aorta ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe Generalized atherosclerosis & cardiomegaly + left ventricular failure Atelectasis of LLL II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atrophy of R kidney due to atherosclerotic occlusion of renal artery			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -		
22. I certify that (I) (this hospital) attended the deceased from 1-16-65 to 1-16-65, that (I) (we) last saw the deceased alive on 1-16-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Lawrence J. Lieberman				23B. DATE SIGNED 1-16-65		
23C. PHYSICIAN'S NAME (Type) Lawrence J. Lieberman				23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 20, 65		24C. NAME OF CEMETERY or CREMATORY Prospect		
				24D. LOCATION (City, town, or county) (State) Seven Valleys Penna.		
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR William J. Dickner + Son North + Balto		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0601		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Clara H. McKenney		January 15, 1965 12³⁰ P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-15			
FULL NAME OF HOSPITAL OR INSTITUTION Methodist Home for the Aged 2211 West Rogers Avenue Baltimore, Maryland 21209		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue 9		9. AGE (In years last birthday) 82			
5. SEX Female 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 9/25/1882		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin G. Hayden		14. MOTHER'S MAIDEN NAME Mary Catherine Cunkle			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 217-48-3796		17. INFORMANT Methodist Home for the Aged	
18. 443X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage		(A) DUE TO		(B) Hypertensive cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(C) DUE TO		(D) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10 January 1965 to 15 January 1965 , that (I) (we) last saw the deceased alive on 15 January 1965 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W Barnaby				23B. DATE SIGNED 16 Jan 65	
23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY				23D. ADDRESS 1531 E North Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Ceme tery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons			
25D. ADDRESS Baltimore, Md. 17		25E. ADDRESS 2 P.O. Avenue			



FUNERAL DIRECTOR: IMPORTANT

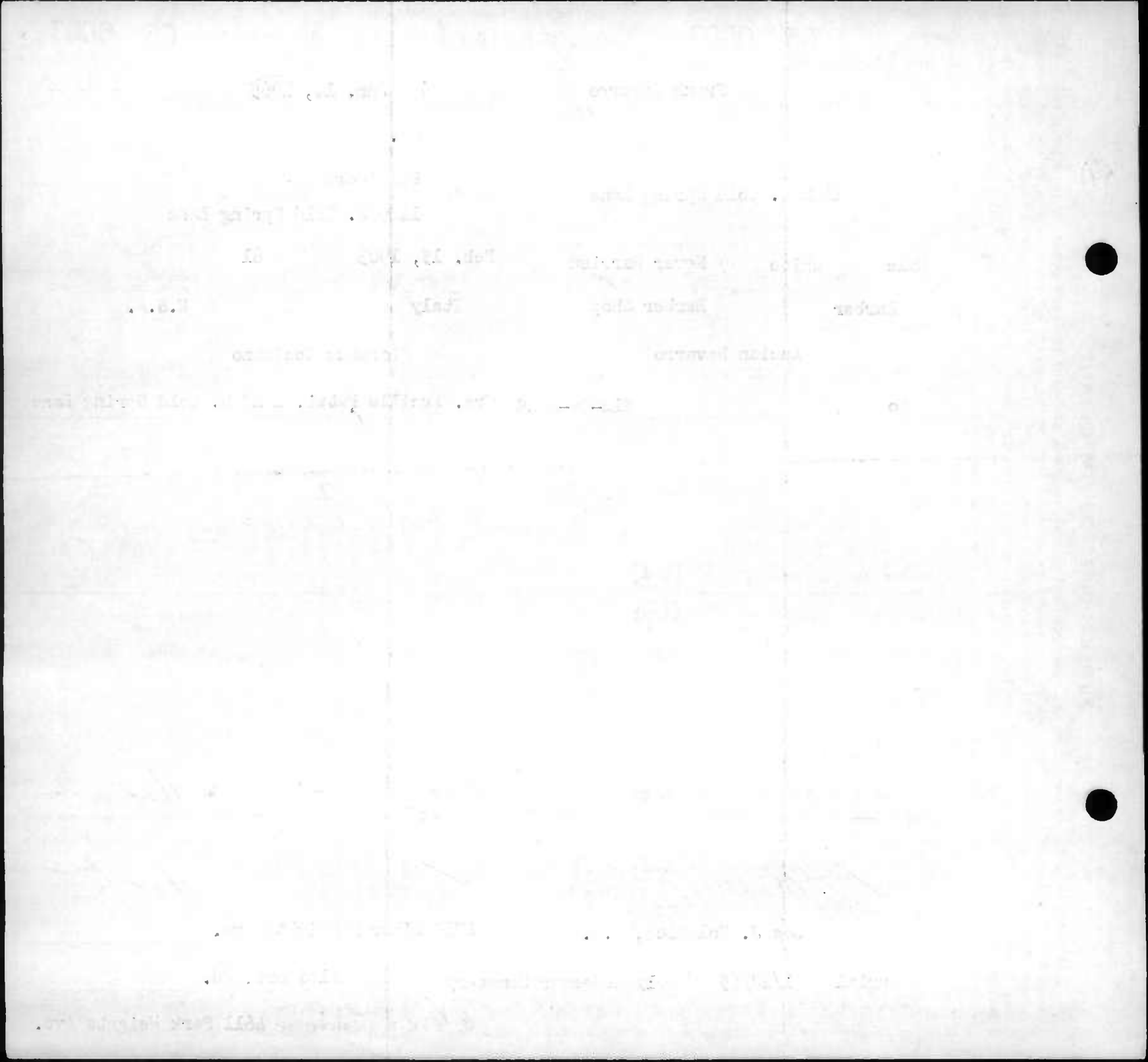
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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0602	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0602					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Lula W. Reese		2. DATE AND HOUR OF DEATH January 14, 1965 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines - Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Villa Nova D. STREET ADDRESS (If rural, give location) 4028 Raleigh Road 8			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/1/1885	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Crapo, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Samuel J. Wheatley			
14. MOTHER'S MAIDEN NAME Lucy Burnestin		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none			
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Walter P. Reese, Jr. ADDRESS 4028 Raleigh Road Villa, Nova 8			
18. 153.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cause of death Ca of Colon		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 mo	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 30 19 64 to Jan 14 19 65 and that (I) (we) last saw the deceased alive on Jan 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman		23B. DATE SIGNED 1/15/65		23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN	
23D. ADDRESS 3700 PARK HEIGHTS AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 1/18/1965		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm. F. Fisher + Sons Baltimore, Md. 21217	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0603</u>	
BIRTH NO. <u>65 0603</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>Jan. 14, 1965</u> <u>6 35 A</u> M.			
1. NAME OF DECEASED (Type or Print) Frank Navarro		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1420 W. Cold Spring Lane		D. STREET ADDRESS (If rural, give location) 1420 W. Cold Spring Lane			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Feb. 15, 1903</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Lucian Navarro</u>		14. MOTHER'S MAIDEN NAME <u>Florence Cosinano</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-0728</u>		17. INFORMANT ADDRESS <u>Mrs. Lucille Patti, 1418 W. Cold Spring Lane</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Coronary occlusion</u> (B) <u>Angina Pectoris</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> 19 <u>63</u> to <u>1/14</u> 19 <u>65</u> . that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/14/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lee J. Volenick, M.D.</u>		23D. ADDRESS <u>4710 Liberty Heights Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/18/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jarboe, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>B. Vernon Lemmon, 4611 Park Heights Ave.</u>			



65 0604		BALTIMORE CITY HEALTH DEPARTMENT		65 0604	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO. 59322					
1. NAME OF DECEASED (Type or Print)		ARMANDA HUNTER		2. DATE AND HOUR PRONOUNCED DEAD January 14, 1965 10:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-03 D. STREET ADDRESS (If rural, give location) 906 N. Gilmore Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1-29-1894	9. AGE (In years last birthday) 70	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK.		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT I. Moody	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 420.0 + 161X Arteriosclerotic Heart Disease.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Garcinoma of Larynx.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 1/14/65					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-16-65		23C. NAME OF CEMETERY or CREMATORY Mt Auburn	
23D. LOCATION (City, town, or county) (State) Baltimore Md.					
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Morton + Dyett	
24D. ADDRESS 916 Penna Ave.					

VALLEY POLICE

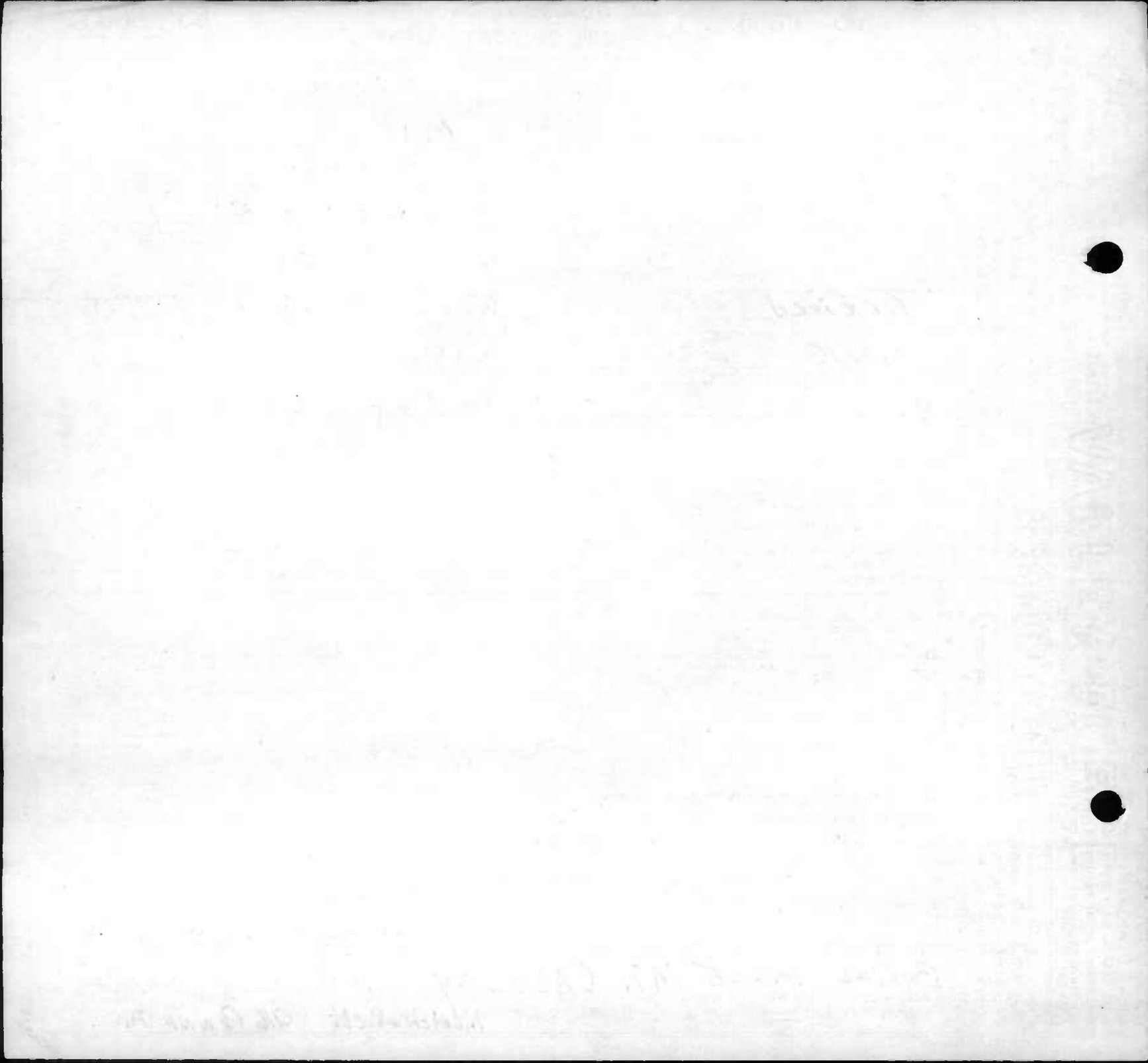
Clarence J. [Signature]

11-11-62 11:15 AM
11-11-62 11:15 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0605				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0605	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Seymour Fisher</i>				2. DATE AND HOUR OF DEATH <i>1-14-65</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY <i>17-01</i>	
<i>27 N Carey St. Baltimore, 23 Md.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>537 W. Biddle St.</i>							
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>S</i>	8. DATE OF BIRTH <i>12-12-1881</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>UNK.</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Knocking</i>		
					ADDRESS <i>537 W. Biddle St.</i>		
18. <i>442X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Cardiovascular Renal ?</i> (A) DUE TO <i>DISEASE</i> (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 4 1964</i> to <i>Jan 14 1965</i> , that (I) (we) last saw the deceased alive on <i>1-14 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>N/A</i>							
23A. SIGNATURE <i>Wm. Johnson</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1-14-65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Medical Art Building</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-16-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. CALVERY</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>		25C. FUNERAL DIRECTOR <i>Morton + Dyett</i>		ADDRESS <i>916 PENNA AVE.</i>	



1
H-200
M-246

65 0606

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0606

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LUCY

HOUSE (McCLURE)

2. DATE AND HOUR PRONOUNCED DEAD

January 14, 1965

11:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1105 Argyle Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1105 Argyle Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

1-18-1917

9. AGE (In years last birthday)

47

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Woolridge

14. MOTHER'S MAIDEN NAME

Daisy Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-14-3430

17. INFORMANT

ADDRESS

Preston McClure 1105 Argyle Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Generalized peritonitis

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

rupture of tubo-ovarian abscess

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-18-65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

Ba 1 to.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1965

24B. NAME OF REGISTRAR

Robert E. Fink, M.D.

24C. FUNERAL DIRECTOR

Morton Dyett

ADDRESS

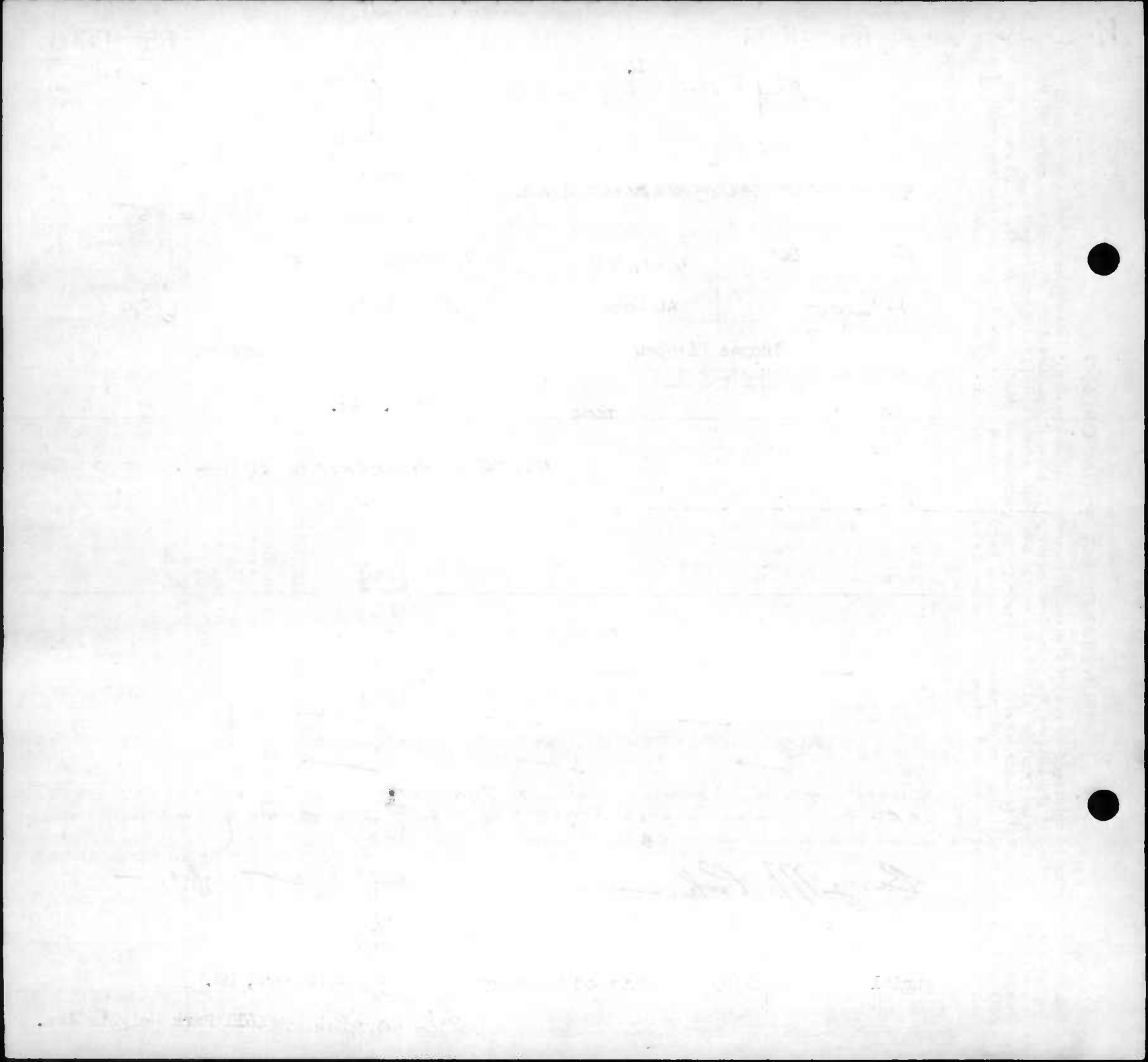
916 Penna Ave., 21201

WALTER PROFFER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

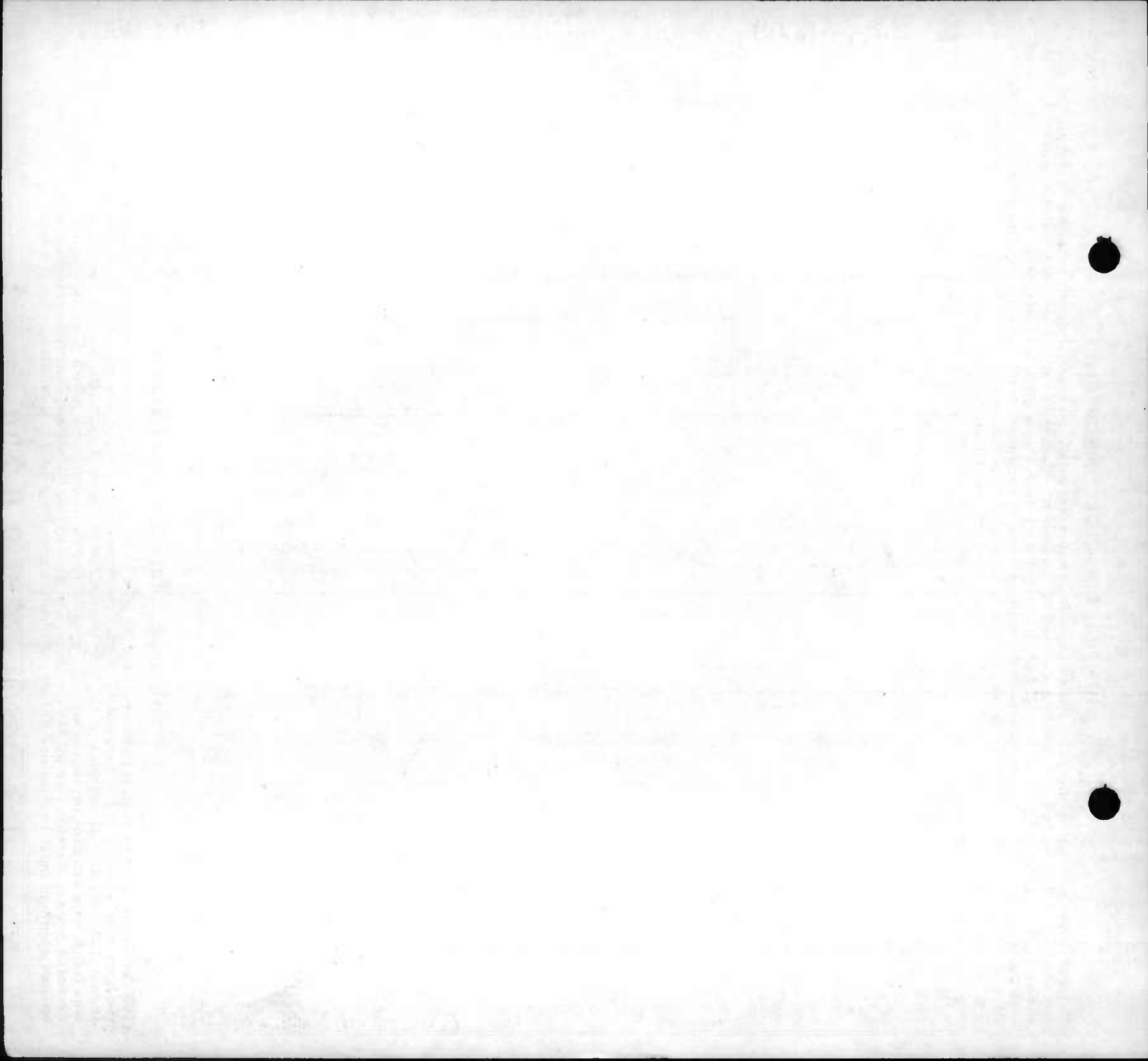
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0608	
BIRTH NO. 65 0608		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MATHER, EVELYN L.		2. DATE AND HOUR OF DEATH 18 JANUARY 1965 4:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-31			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE, INC.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 4111 SUNNYSIDE AVE, #15	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/15/13	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H'WIFE		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Thomas Fishpaw		14. MOTHER'S MAIDEN NAME ? unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Hosp. Rec.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 204.31-260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ACUTE LYMPHOBLASTIC LEUKEMIA DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH ABOUT 3 WEEKS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETIC KETOSIS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8 JANUARY 1965 to 18 JANUARY 1965 , that the (we) last saw the deceased alive on 18 JANUARY 1965 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE Barry M. Cohen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR L. Vernon Lemmon		ADDRESS 4611 Park Heights Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

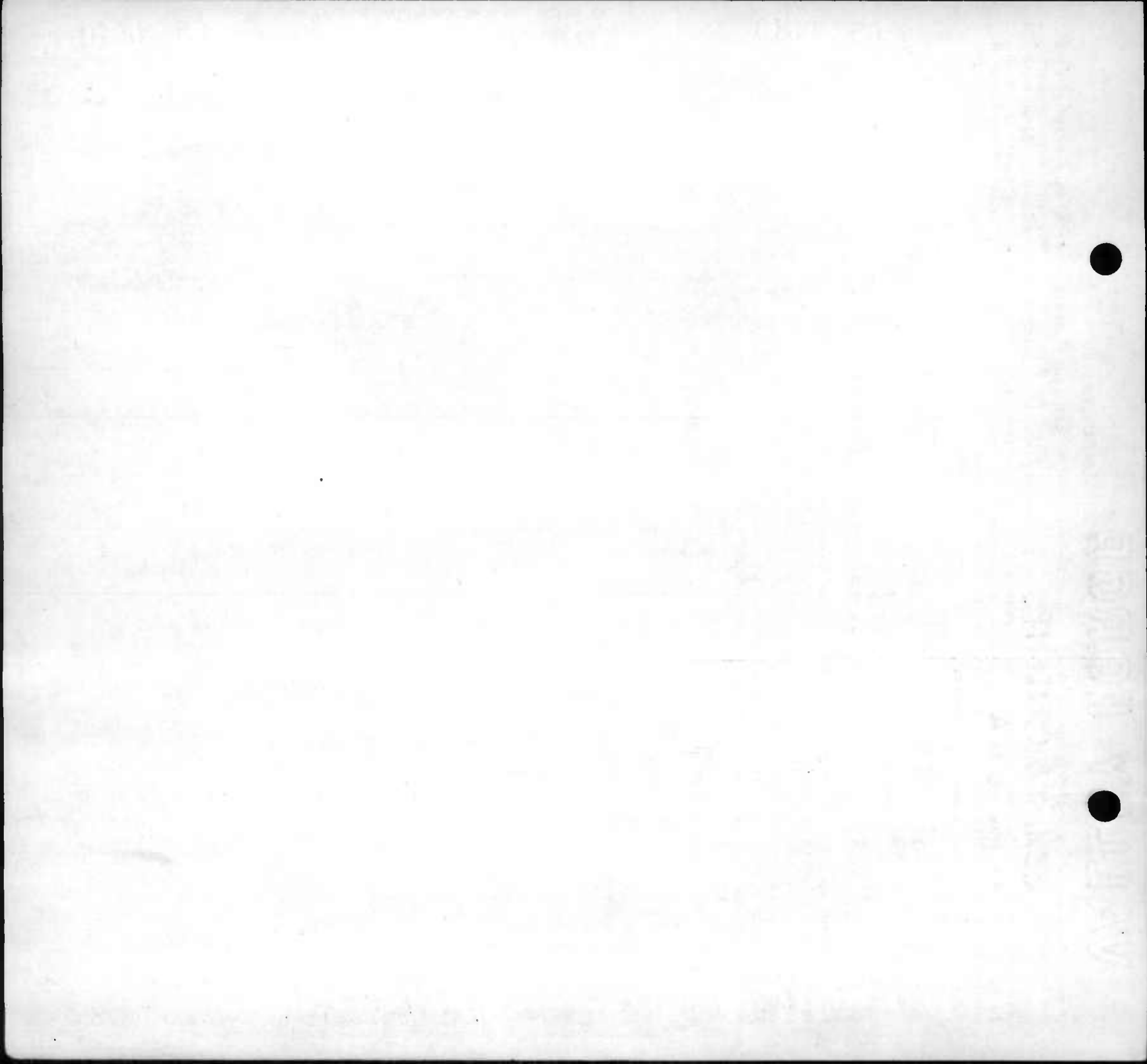
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0609	
BIRTH NO. 65 0609		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VIOLA MOOG		2. DATE AND HOUR OF DEATH 16th JAN 1965 2:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution, give address before admission) A. STATE MD COUNTY BALTIMORE 20 Peble Drive		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION The Hospital For The Women of Maryland		D. STREET ADDRESS (If rural, give location) 20 Peble Drive		52-00	
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12/6/1892	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) AA County Md	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME William Henry Roles		14. MOTHER'S MAIDEN NAME MARY JANE Roles	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Charmee Moog - 5710 Anthony Ave Baltimore 6, Md.	
18. 420.1 I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 24 1964 to JAN 16 1965 , that (I) (we) last saw the deceased alive on JAN 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-16-65	
23C. PHYSICIAN'S NAME (Type) Dr. D. D. Kulkarni		23D. ADDRESS Women's Hospital Baltimore 17 Md. U.S.A.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY Balti Cem.	
24D. LOCATION Balti		24E. LOCATION Balti		24F. LOCATION Balti	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son	
				ADDRESS Balti Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

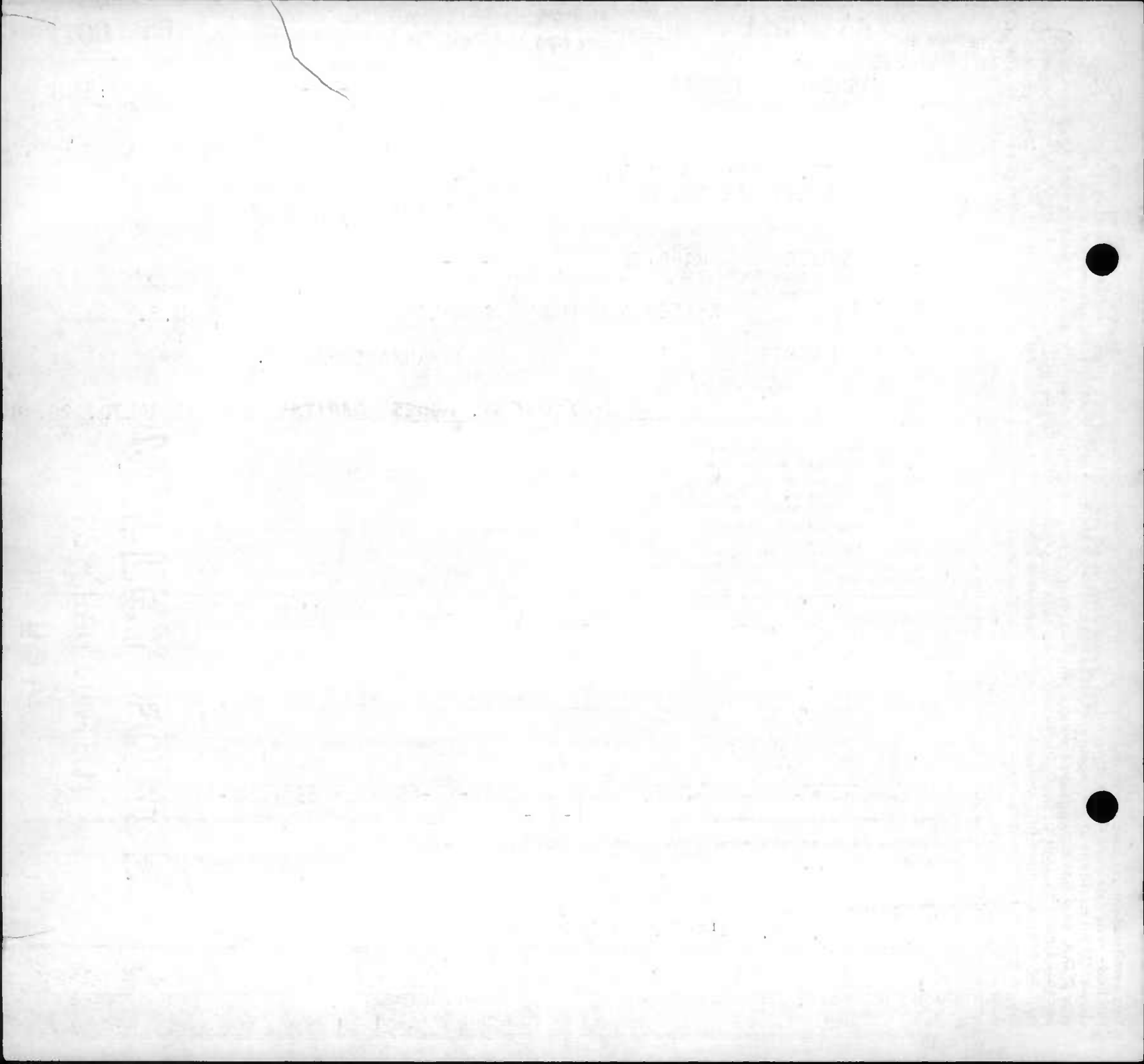
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0610	
BIRTH NO. 65 0610				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) MYRTLE V. KESSLER				2. DATE AND HOUR OF DEATH 1/18/65 2:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.				A. STATE Md.		B. COUNTY 21-02	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1115 Sargeant St - (30)							
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/2/1904	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Birmingham				14. MOTHER'S MAIDEN NAME Lucy Hunt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Frank Kessler 1115 Sargeant St			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Carcinoma of Ovary		6 years	
				(B) DUE TO Hypertension P.V.D.		2 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1/18/65 11:00 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 19 58 to Jan 18 19 65, that (I) (we) last saw the deceased alive on Dec 2 19 64 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul Schinfeld				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) PAUL SCHONFELD				23D. ADDRESS 2301 Annapolis Rd. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/65		24C. NAME OF CEMETERY or CREMATORY Pleasant Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John J. Conner, Inc.		ADDRESS 901 Hallams St. Balt. 23, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

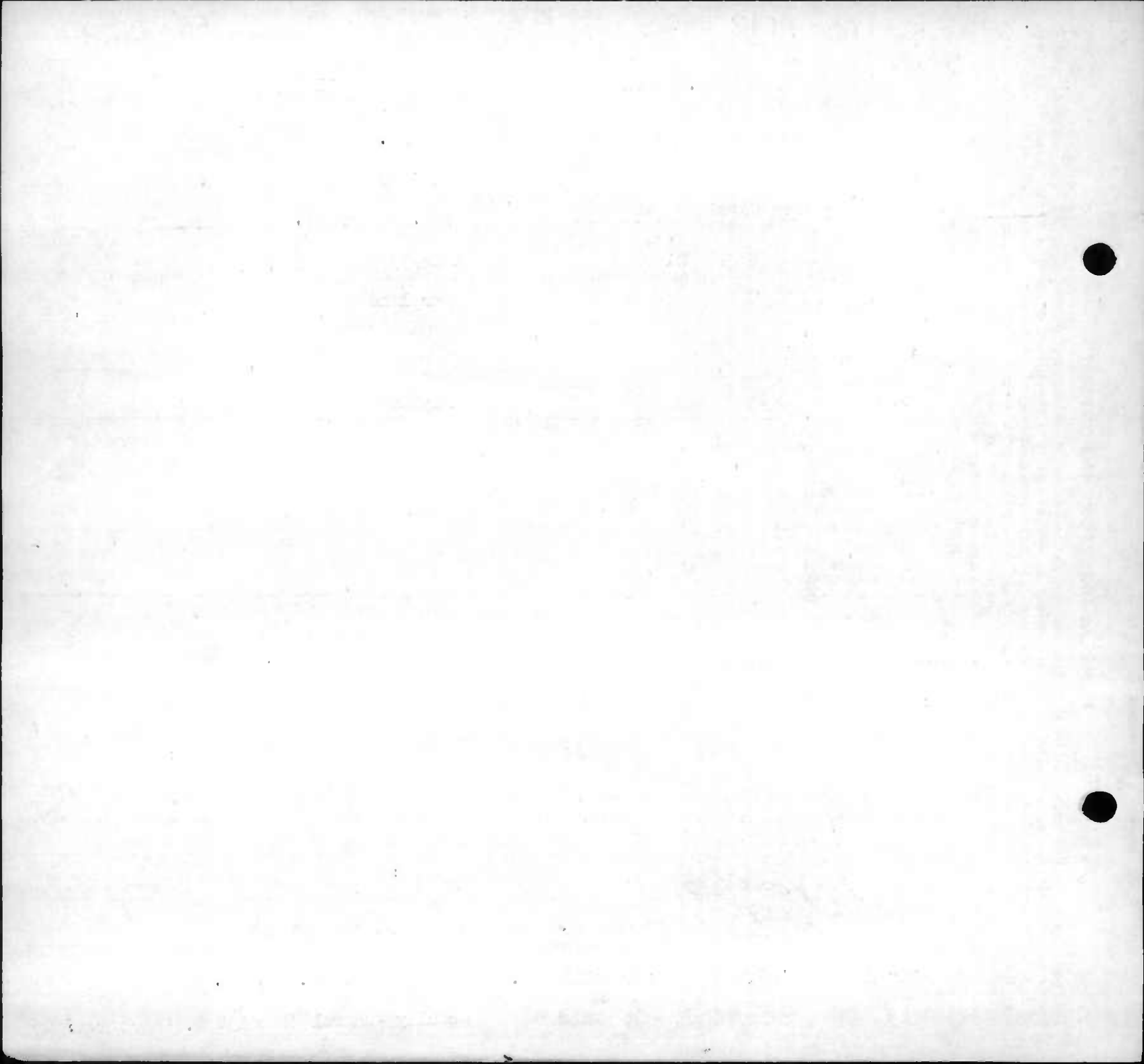
BALTIMORE CITY HEALTH DEPARTMENT													
BIRTH NO. 65 0611						REGISTERED NO. 65 0611			BALTIMORE CITY HEALTH DEPARTMENT				
CERTIFICATE OF DEATH													
1. NAME OF DECEASED (Type or Print) HAGNER, THOMAS						2. DATE AND HOUR OF DEATH 1-17-65 3:55 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE 29, MD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5510 IVANHOE AVENUE							
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 9-10-15		9. AGE (in years last birthday) 49		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10B. KIND OF BUSINESS OR INDUSTRY KEISER ALUMINUM				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JOSEPH HAGNER						14. MOTHER'S MAIDEN NAME JOHANNA SCHAEFFER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-05-9350		17. INFORMANT ST. AGNES HOSPITAL RECORDS BALTO. 29, MD				ADDRESS			
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) Cerebro-vascular accident DUE TO (B) hypertension DUE TO (C) several years						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (the) (this hospital) attended the deceased from 1-16-65 19 65 to 1-17 19 65 , that (I) (we) last saw the deceased alive on 1-17- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) XXXX view the body after death.													
23A. SIGNATURE F. D. D'ARCHY						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1-17-1965			
23C. PHYSICIAN'S NAME (Type) F. D. D'ARCHY, MD						23D. ADDRESS St. Agnes Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY Interfaith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Balto Md							
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farber				25C. FUNERAL DIRECTOR Wm. G. Calhoun				ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

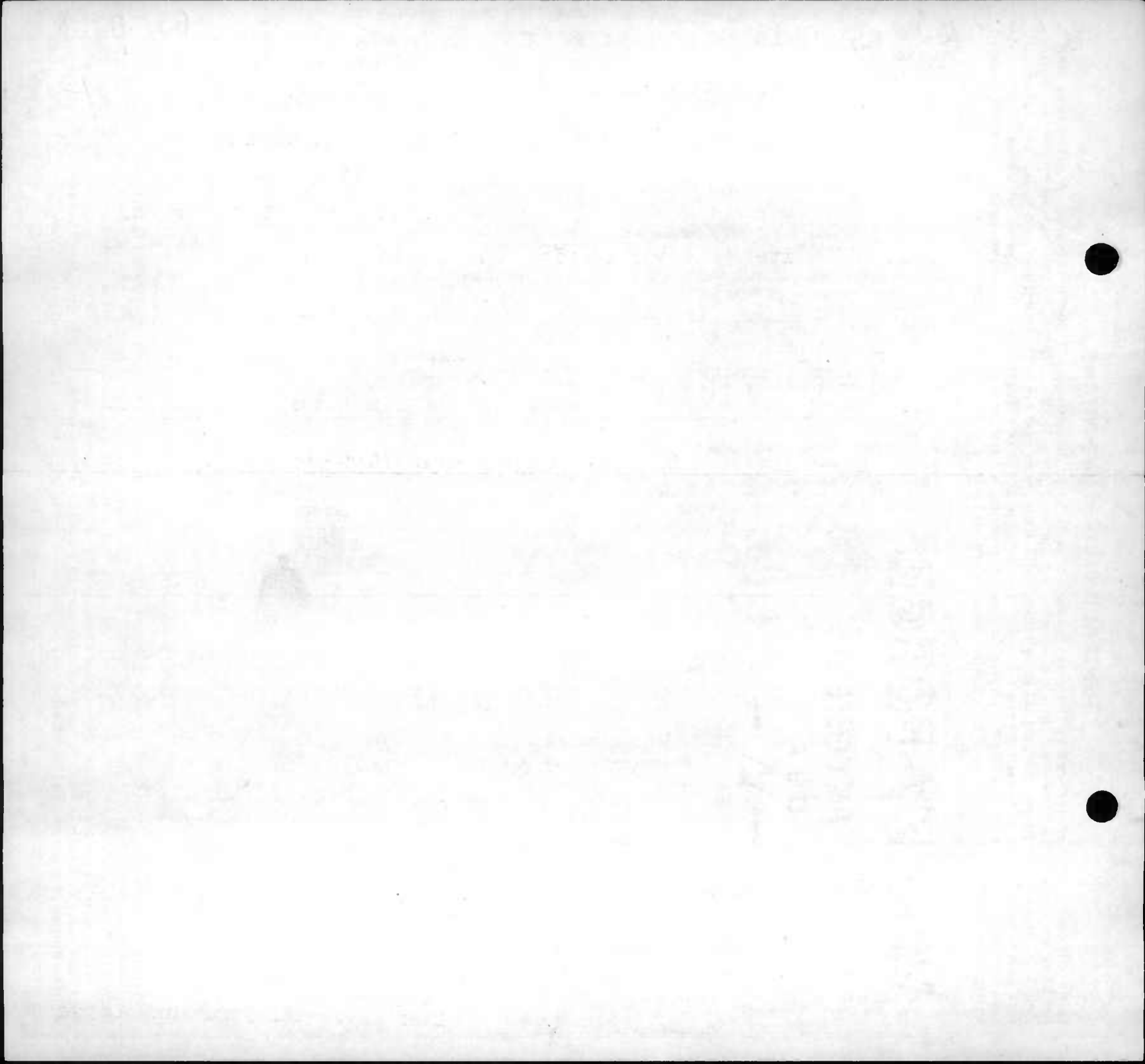
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0612	
BIRTH NO. 65 0612				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LILLIE A. BALIA		2. DATE AND HOUR OF DEATH 1/16/65 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Garrison Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY 2303 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 9 E. Barney St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/26/79	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Heim		14. MOTHER'S MAIDEN NAME Mary Sachs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family ADDRESS Same	
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arterio sclerosis due to senility		CAUSE OF DEATH (A) Memia DUE TO Arterio sclerosis (B) Cerebro Vascular Disease DUE TO Senility (C) Senility		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 12 1963 to Jan 16 1965 that (I) (we) last saw the deceased alive on January 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 6:30 p.m.					
23A. SIGNATURE M. Paul Byerly		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) M Paul Byerly		23D. ADDRESS M.D. 5820 York Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/65		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem.	
24D. LOCATION Balto. 25, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR McCully Funeral Home 130 E. Fort Ave.	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0613	
BIRTH NO. 65 0613		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harry Joseph Clark		2. DATE AND HOUR OF DEATH January 18-65 100 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6200 Elliott St			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Fort Howard Maryland D. STREET ADDRESS (If rural, give location) 35 Denton Ave RT 10 Box 352		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 7-25-1896	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Harry J. Clark			12. CITIZEN OF WHAT COUNTRY? U S A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII			16. SOCIAL SECURITY NO. 213-07-5556		17. INFORMANT Mrs Emma Waters 6200 Elliott At
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinoma of the Esophagus DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 29 1964 to Jan 18 1965 , that (I) (we) last saw the deceased alive on Jan 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen C. Mackowiak M.D.				23B. DATE SIGNED 1-18-65	
23C. PHYSICIAN'S NAME (Type) Stephen C. Mackowiak				23D. ADDRESS M.D. 6714 Holibird Avenue	
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE I-21-65		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley M.A.		25C. FUNERAL DIRECTOR Walter Dabrowski ADDRESS 1005 Dundalk Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0614</u>	
BIRTH NO. <u>65 0614</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Catherine RUPP</u>		2. DATE AND HOUR OF DEATH <u>JAN. 14, 1965</u> <u>7:30 a.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>28-04</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4300 OLD FREDERICK RD.</u>		D. STREET ADDRESS (If rural, give location) <u>4300 OLD FREDERICK AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT. 11, 1881</u>	9. AGE (In years lost birthday) <u>83</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>THEODORE SCHENNING</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE GARRISON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Henry Rupp - 4300 Old Frederick Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>13334260X</u>		CAUSE OF DEATH (A) <u>Amular carcinoma of the sigmoid.</u> DUE TO (B) <u></u> DUE TO (C) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes mellitus.</u> <u>Arteriosclerotic heart disease with congestive failure.</u>				<u>5 years</u>	
19A. DATE OF OPERATION <u>Dec. 1963</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Colestomy for sigmoid CA.</u>		20A. AUTOPSY? (Yes or No) <u>No.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5,</u> 19 <u>64</u> to <u>Jan. 14,</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan. 14,</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Alfred Cole</u> M.D.				23B. DATE SIGNED <u>1/14/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alfred Cole,</u> M.D.				23D. ADDRESS <u>136 S. Hilton St. Baltimore 29, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-18-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Garbey, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frederick Funeral Home, Catonsville, Md.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0615

BIRTH NO. 65 0615

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Mary Agnes Manner

2. DATE AND HOUR OF DEATH

Jan. 12, 1965

7³⁰ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

5354 Perring Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5354 Perring Parkway

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Oct. 31, 1886

9. AGE (In years
last birthday)

78

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael McNeive

14. MOTHER'S MAIDEN NAME

Mary McKewen

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

ADDRESS

Gertrude Mullen-2015 Northbourne Rd

18. 420.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Acute Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

5 hrs.

(B) DUE TO

Arteriosclerotic CVD

20 yrs.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pleurisy, left

7 days

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY

(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work

Not While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

1958 to Jan 12 1965

that (I) (we) last saw the deceased alive on

Jan 8 1965

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.

23A. SIGNATURE

Joseph F. LiPira

M.D.

Attending
Phys.

☒

Med.
Director

☐

Staff
Phys.

☐

23B. DATE SIGNED

Jan. 13, 1965

23C. PHYSICIAN'S
NAME (Type)

Joseph F. LiPira

M.D.

23D. ADDRESS

8400 Loch Raven Blvd. Balto 4, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-16-65

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1965

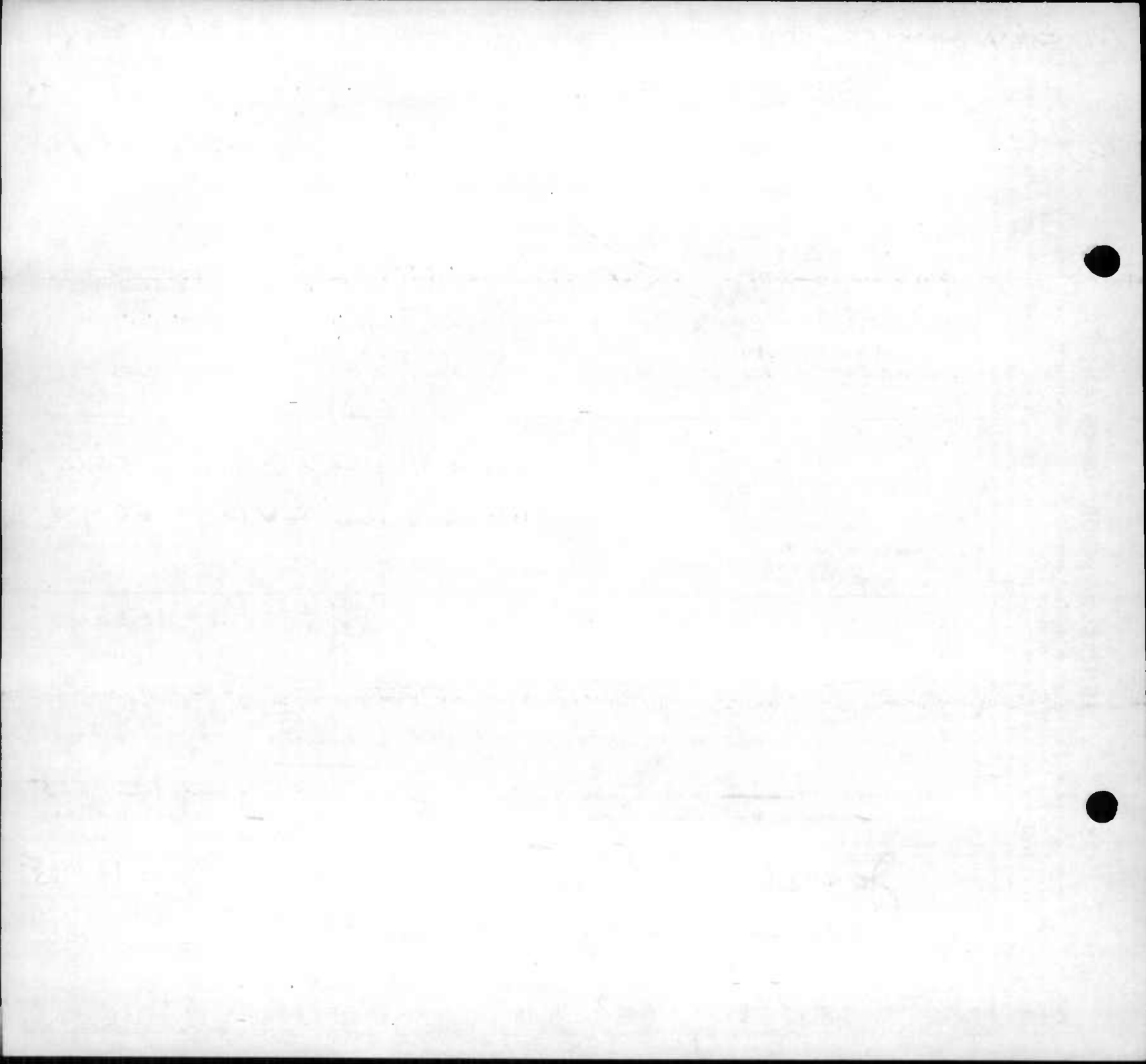
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.

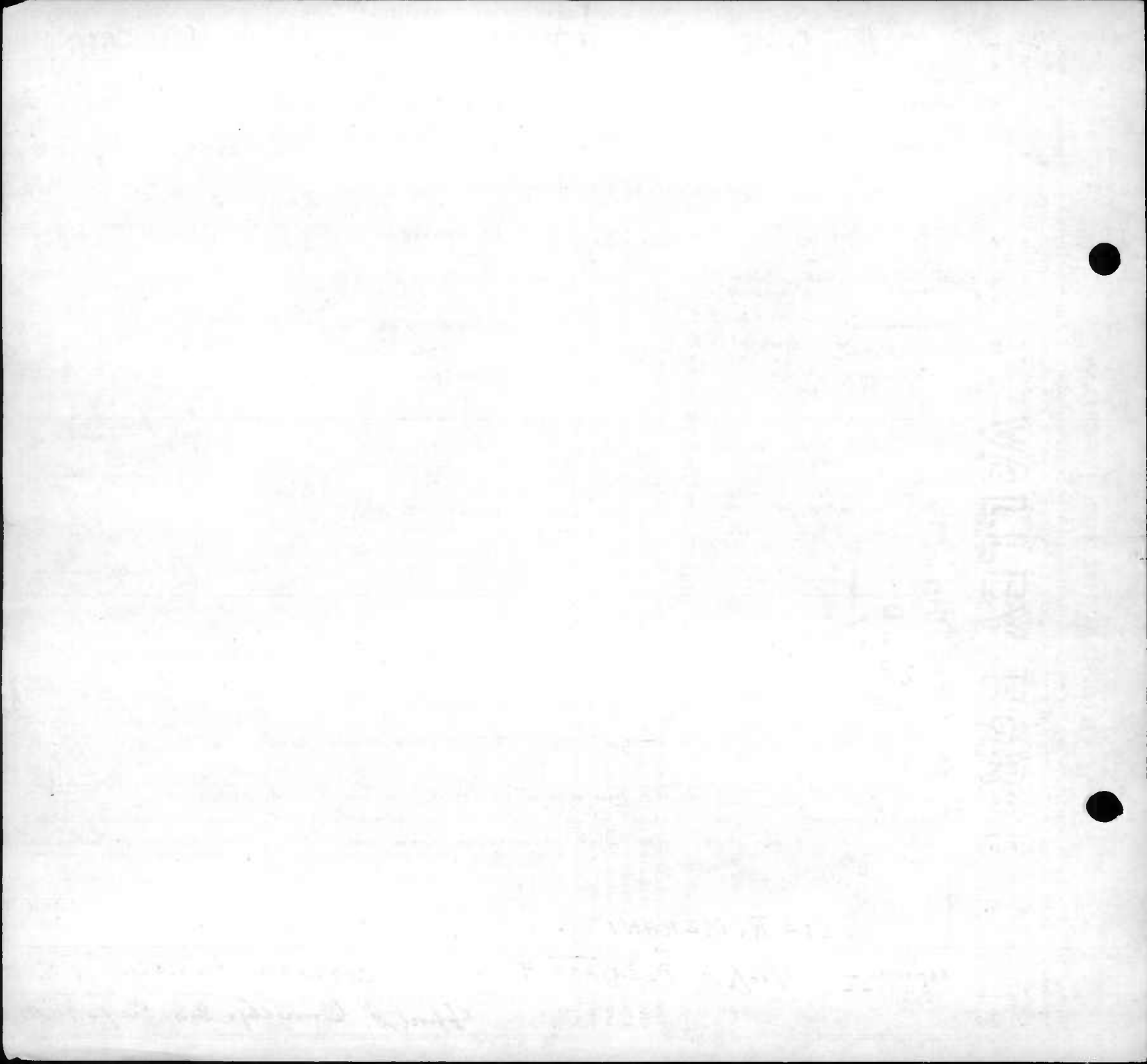
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 0616</u>				
BIRTH NO. <u>65 0616</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>LYDIA WILSON</u>					2. DATE AND HOUR OF DEATH <u>JANUARY 15, 1965 8:50 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MONTEBELLO STATE HOSPITAL</u>					A. STATE <u>MARYLAND</u>				
					B. COUNTY <u>BALTO.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>53-00</u>				
					D. STREET ADDRESS (If rural, give location) <u>BOX 76 A ROUTE 10</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1-9-1885</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARMENT WORKER</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ISAAC BEESMER</u>					14. MOTHER'S MAIDEN NAME <u>PHILINDA ECKERT</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT ADDRESS <u>HOSPITAL RECORDS MONTEBELLO</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				
					(A) <u>PULMONARY EMBOLISM</u>				
					(B) <u>PARKINSONISM</u>				
					(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 2, 1963</u> to <u>JANUARY 15, 1965</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 15, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Elsa R. Merani</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>January 15, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELSA R. MERANI</u>					23D. ADDRESS <u>Montebello State Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL + BURIAL</u>		24B. DATE <u>1/16/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>PLEASANT HILL</u>		24D. LOCATION (City, town, or county) (State) <u>CORNWALL ORANGE CO. N. Y.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>			25C. FUNERAL DIRECTOR ADDRESS <u>John G. Connelly & Sons Corp - Ind.</u>			

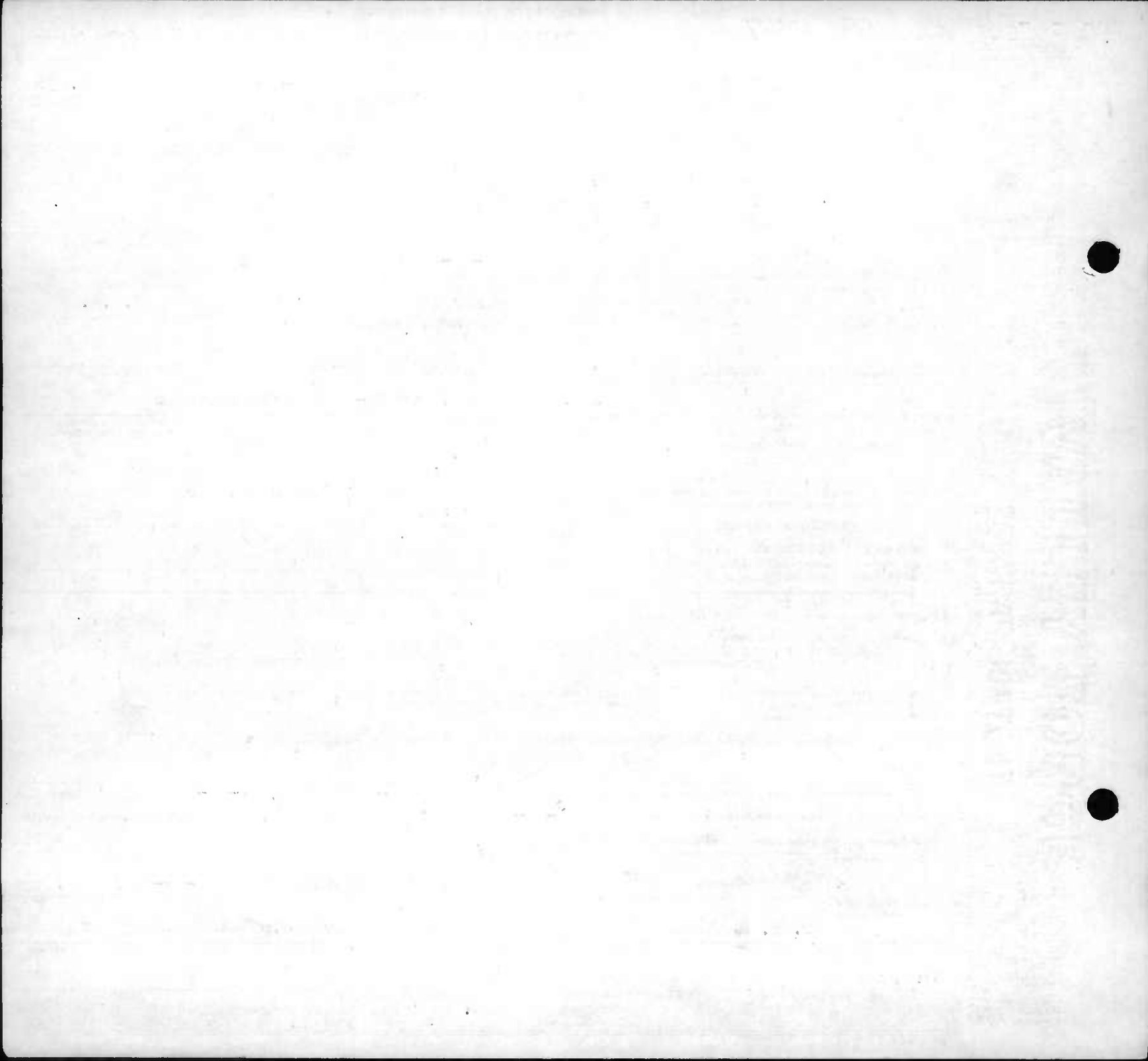


CERTIFICATE OF DEATH X Registered No. 65 0617

BIRTH NO. 65 0617		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Elfie Siemek		2. DATE AND HOUR OF DEATH 1-15-1965 2.05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland, 21224		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto D. STREET ADDRESS (If rural, give location) 2108 Firethorn Road, 21220 53-00	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-19-1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 72
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T.		14. MOTHER'S MAIDEN NAME Mamie Lillian Koch	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Records: BCH -4940 Eastern Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433.041260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus		CAUSE OF DEATH (A) Cardiac Arrest DUE TO Arteriosclerotic Cardiovascular Disease (B) 20 years (C) 25 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-14-1965 to 1-15-1965 , that (I) (we) last saw the deceased alive on 1-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H. Rathbun		23B. DATE SIGNED 1-15-1965	
23C. PHYSICIAN'S NAME (Type) Dr. H. Rathbun		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/19/65	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965	25B. NAME OF REGISTRAR Robert E. Farley, M.D.	25C. FUNERAL DIRECTOR Nicholas T. Matthews 3021 Eastern Ave, Baltimore 24, Md.	

FUNERAL DIRECTOR: IMPORTANT

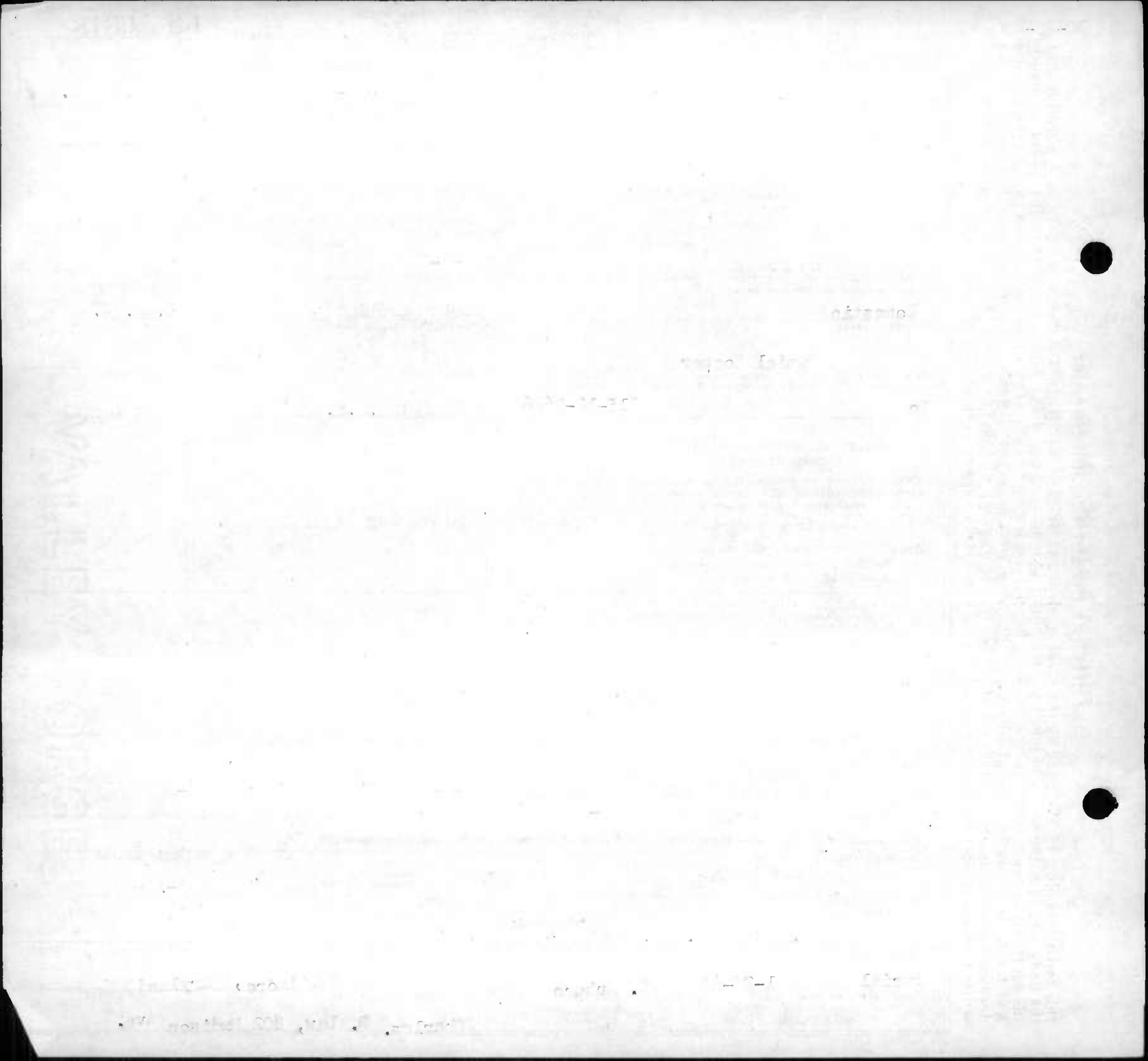
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0618	
BIRTH NO. 65 0618				CERTIFICATE OF DEATH	
M.E. CASE NO. 65 0618				2. DATE AND HOUR OF DEATH 1-16-65 6:15 A. M.	
1. NAME OF DECEASED (Type or Print) Cora Bell Walker				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-06	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3111 Walbrook Avenue #21216	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	B. DATE OF BIRTH 5-1-05	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Daniel Hooper			14. MOTHER'S MAIDEN NAME P		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-12-9686		17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Pemphigus DUE TO (B) Gram Negative Sepsis DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH 6 Years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-5-1965 to 1-16-1965 and that (I) (we) last saw the deceased alive on 1-16-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 1-16-65	
23C. PHYSICIAN'S NAME (Type) Dr. Howard K. Rathbun				23D. ADDRESS 4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0619					CERTIFICATE OF DEATH					Registered No. 65 0619				
1. NAME OF DECEASED (Type or Print) BREITSCHWERDT, MARY E.					2. DATE AND HOUR OF DEATH JANUARY 15, 1965 1:10 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto.									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKRIDGE					D. STREET ADDRESS (If rural, give location) BOX 218, ROUTE 4 53-00				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 3-7-03		9. AGE (In years last birthday) 61		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) MARYLAND				
12. CITIZEN OF WHAT COUNTRY? U.S.					13. FATHER'S NAME JOHN G SMITH					14. MOTHER'S MAIDEN NAME ANNIE FRISCEI				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.					17. INFORMANT CATON SAVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 ACUTE PULMONARY EDEMA HYPOCAUSAL DISSECTION					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1-13-19 65 to 1-15-65 that (I) (we) last saw the deceased alive on 1-15-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Edilberto Beltran					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 1-15-65				
23C. PHYSICIAN'S NAME (Type) EDILBERTO BELTRAN					23D. ADDRESS M.D. ST AGNES HOSPITAL, BALTO. 29, MD.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/19/65					24C. NAME OF CEMETERY OR CREMATORY Holy REDEEMER				
24D. LOCATION (City, town, or county) (State) BALTO, Md					25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965					25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				
25C. FUNERAL DIRECTOR A. A. C. M. D.					25D. ADDRESS									

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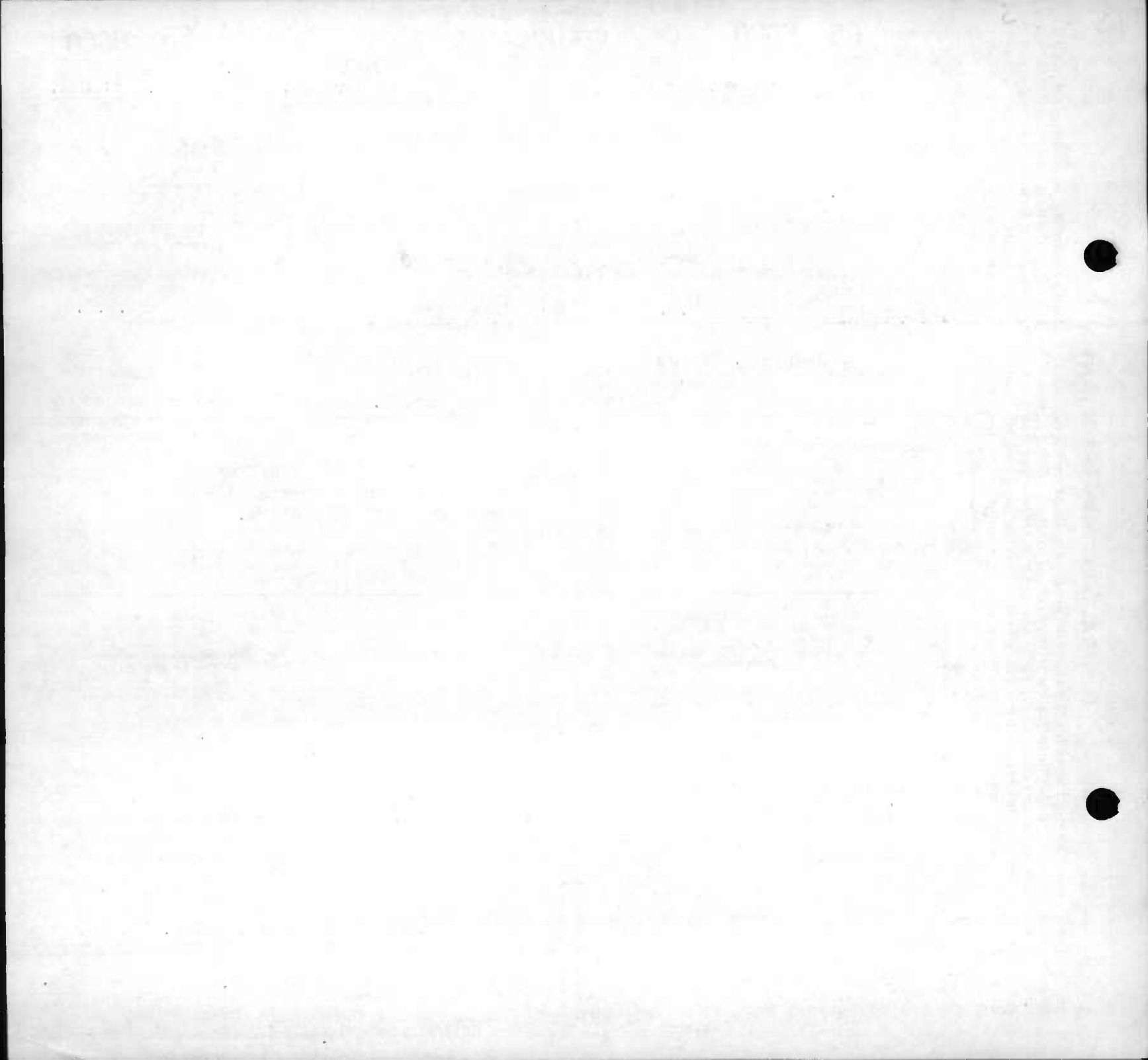
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

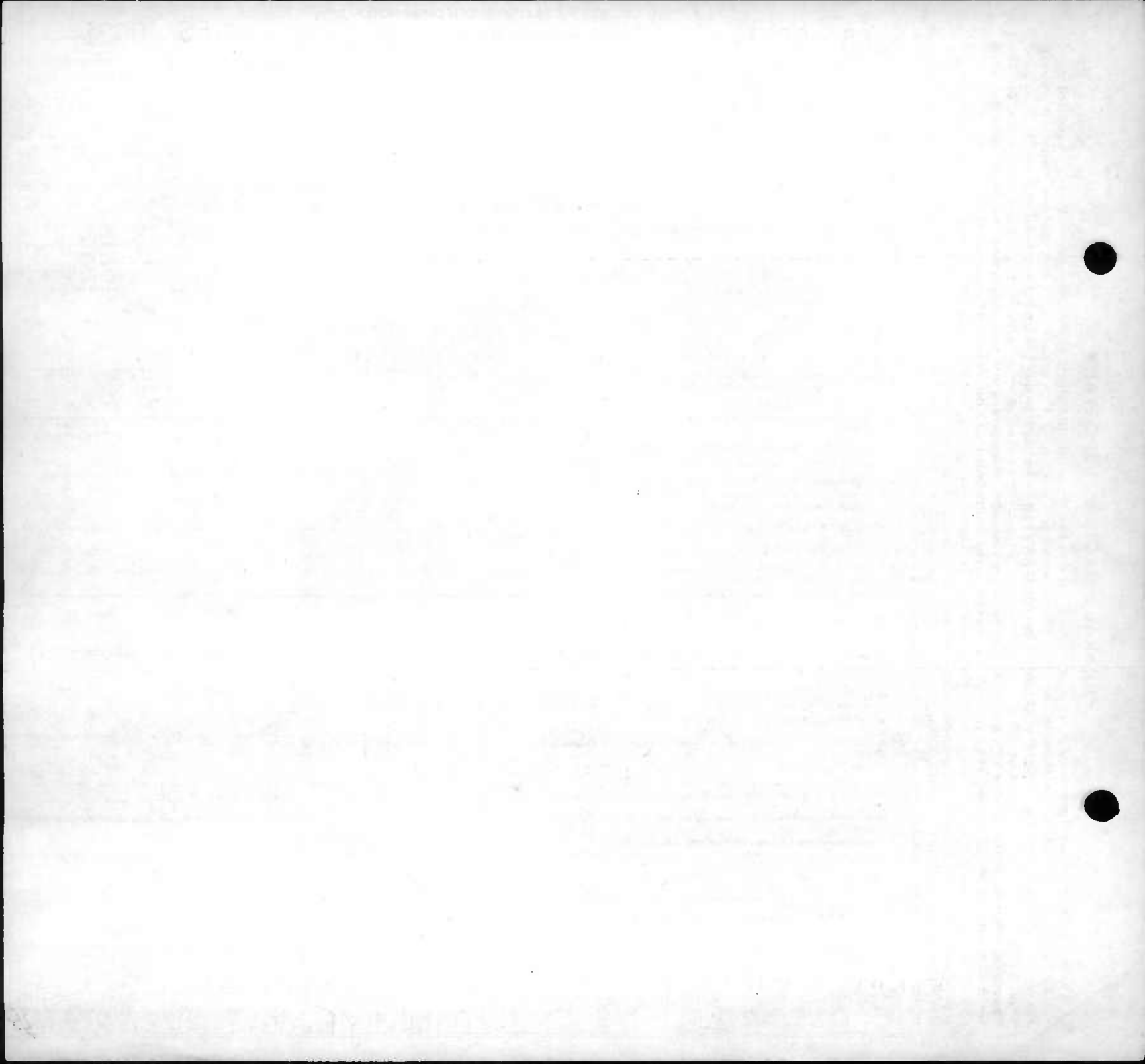
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0620					Registered No. 65 0620				
M.E. CASE NO.					Certificate of Death				
1. NAME OF DECEASED (Type or Print) Benson, Alvan					2. DATE AND HOUR OF DEATH January 15, 1965 8:20 a. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital					A. STATE Maryland				
(If not in hospital) or institution, give street address or location					B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3606 Glenarm Avenue #6				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-30-03	9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joshua E. Benson					14. MOTHER'S MAIDEN NAME Katie Hayes				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11					16. SOCIAL SECURITY NO. 217-03-4933				
17. INFORMANT Mrs Mary V. Benson					ADDRESS 3606 Glenarm Avenue 6				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertension; multiple hemorrhages of brain: right cerebrum mid-brain and left cerebellum.					INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION 2		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) Yes		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
24A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		24B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		24C. HOW DID INJURY OCCUR?					
25. I certify that (I) (this hospital) attended the deceased from January 15, 1965 to January 15, 1965, that (I) (we) last saw the deceased alive on January 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
26A. SIGNATURE William B. Vande Grift, M.D.					26B. DATE SIGNED January 15, 1965				
27A. PHYSICIAN'S NAME (Type) William B. Vande Grift, M.D.					27B. ADDRESS 1400 N. Caroline Street, Balto. 13, Md.				
28A. BURIAL CREMATION, REMOVAL (Specify) Burial		28B. DATE 1-18-1965		28C. NAME OF CEMETERY or CREMATORY Jessups Meth Cemetery		28D. LOCATION (City, town, or county) (State) Baltimore Co. Md.			
29A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		29B. NAME OF REGISTRAR Robert E. Taylor, M.D.		29C. FUNERAL DIRECTOR Lansdown Funeral Home		29D. ADDRESS 7401 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No. 65 0621	
BIRTH NO. 65 0621		65-01249									
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Baby Boy WRIGHT				2. DATE AND HOUR OF DEATH 1-16-65 4:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 9.9.C.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 32-00			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL				D. STREET ADDRESS (If rural, give location) 4934 Brookwood Rd, # 25							
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 1-14-65		9. AGE (In years last birthday)		If Under 1 Yr. : If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard C. WRIGHT						14. MOTHER'S MAIDEN NAME Lucine N. Stewart					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mother				ADDRESS Same	
18. 773.01 CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						(A) Respiratory Distress Syndrome DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Hyaline Membrane Disease DUE TO 1 day 15 hrs					
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-14-65 19 to 1-16-65 19 that (I) (we) last saw the deceased alive on 1-16-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Carlos Abel						M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1-16-65	
23C. PHYSICIAN'S NAME (Type) CARLOS ABEL						23D. ADDRESS M.O. UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-18-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) BALTO, 29, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965				25B. NAME OF REGISTRAR Robert E. Farley, M.D.				25C. FUNERAL DIRECTOR McCully Fun. Home			
								ADDRESS CITY 237 KATHYSCO, 25			



G. 640

33

STN # 114201

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No.

65 0622

BIRTH NO. 65 0622

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Sylvia Grapey

2. DATE AND HOUR OF DEATH

January 16, 1965 7:40 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTYWEST VIRGINIA
C. CITY OR TOWN (If outside city limits, write RURAL and give township)CHARLESTON
D. STREET ADDRESS (If rural, give location)

ROUTE 2 BOX 362

5. SEX
FEMALE6. RACE
WHITE7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED8. DATE OF BIRTH
5-22-179. AGE (In years
last birthday) 47If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

KENNETH DODD

14. MOTHER'S MAIDEN NAME

CHLOE JARRETT

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

180X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Infarction of Large + Small Bowel
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

19 1/2 hours

(B) Superior Mesenteric Artery Occlusion
DUE TO

20 hours

(C) Left Hypernephroma

2 months +

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

January 15/16, 1965

WAS PERFORMED (Left Hypernephroma
Superior Mesenteric Artery Occlusion)

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 14, 1965 to January 16, 1965,
that (I) last saw the deceased alive on January 16, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mark Arthur Neyman

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

January 16, 1965

23C. PHYSICIAN'S
NAME (Type)

DR. MARK ARTHUR NEYMAN

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Removal

1-16-65

South Charleston W. Va

W. Va

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

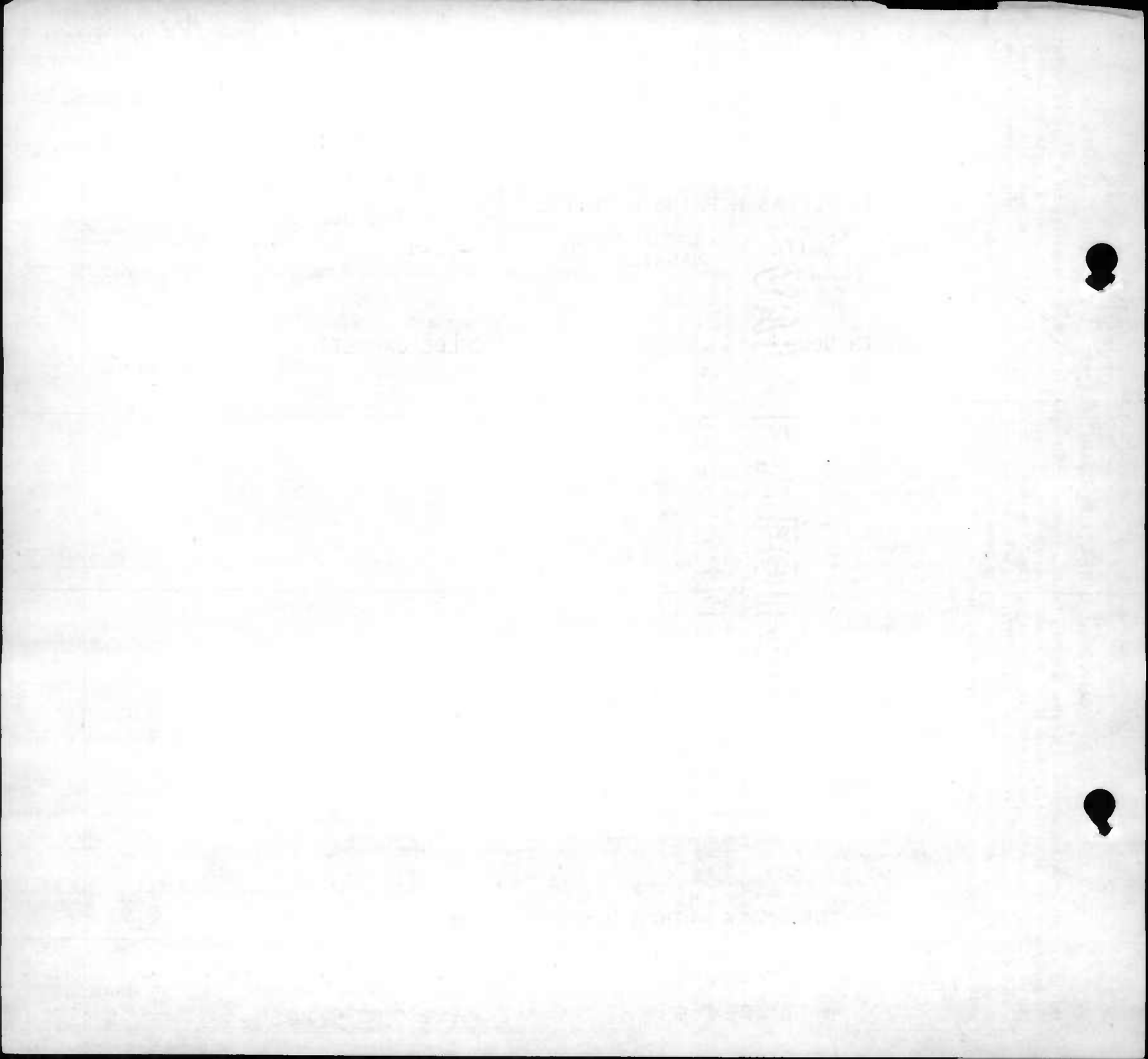
25C. FUNERAL DIRECTOR

ADDRESS

JAN 19 1965

Robert E. Taylor, M.D.

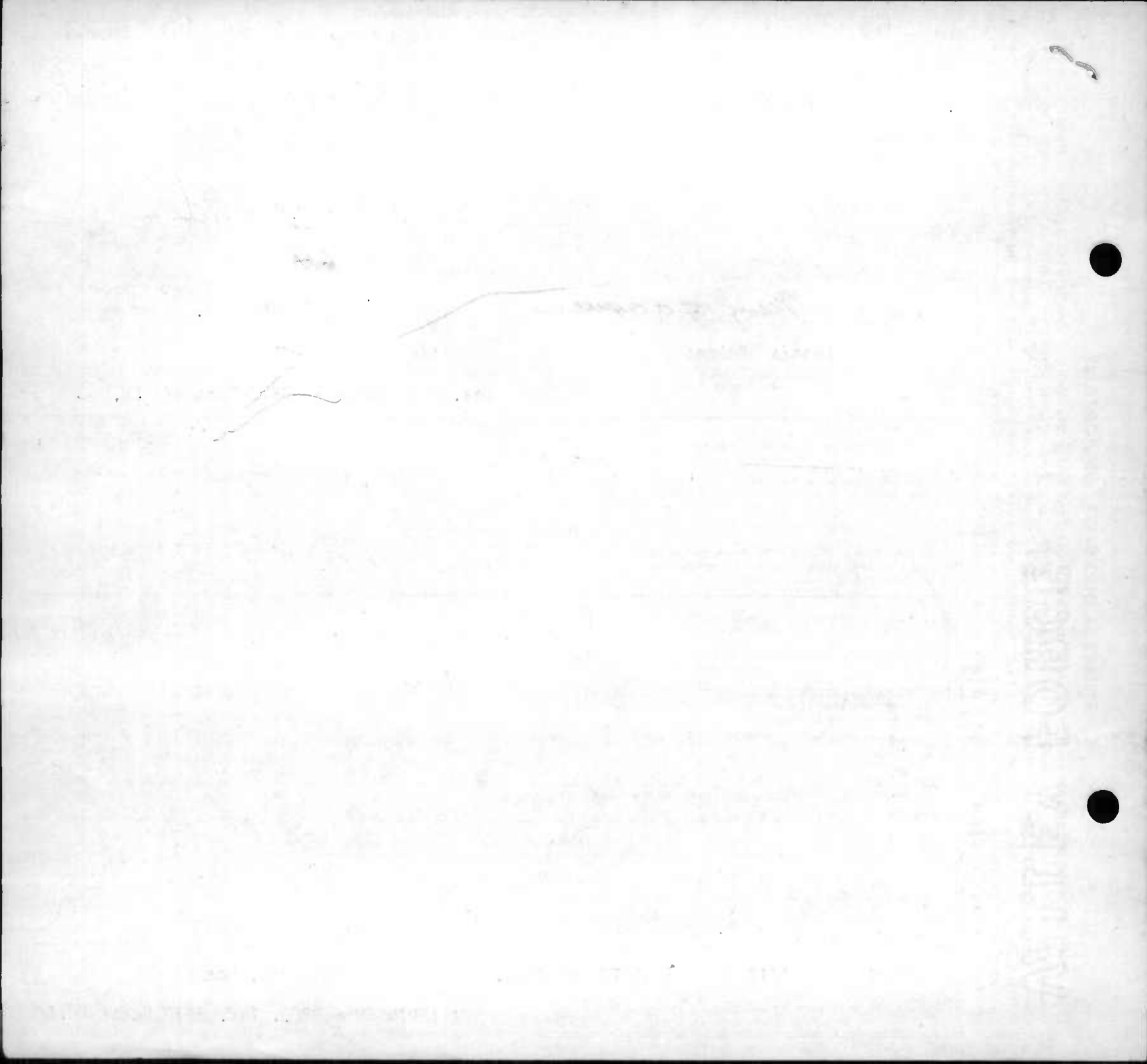
Jack Lewis Inc. 2100 East
Baltimore Rd



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

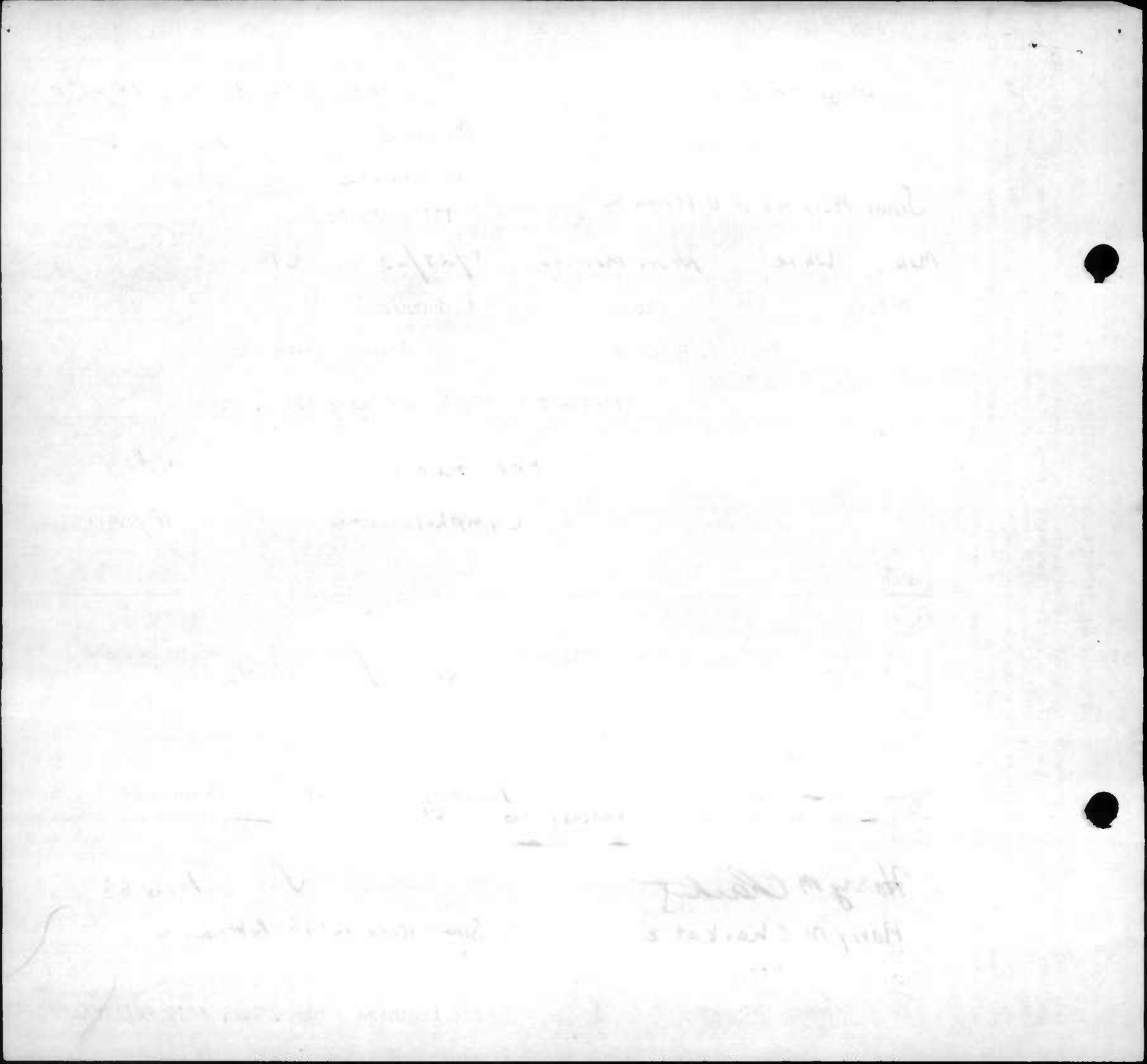
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0623					CERTIFICATE OF DEATH					Registered No. 65 0623				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					1/16/65 1:35 P.M.				
1. NAME OF DECEASED (Type or Print) <u>Jacob Rubens (Jack)</u>					3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>					(If not in hospital or institution, give street address or location)					5. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
6. STREET ADDRESS (If rural, give location) <u>3410 Terrapin Rd</u>					7. SEX <u>Male</u>					8. RACE <u>White</u>				
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>					10. AGE (in years last birthday) <u>64</u>					11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Manager</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Lacquer</u>					11. BIRTHPLACE (State or foreign country) <u>England, London</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>Morris Rubens</u>					14. MOTHER'S MAIDEN NAME <u>Bessie ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS <u>Mrs. Ruth Rubens-- 3410 Terrapin Rd.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>200X I</u>					CAUSE OF DEATH (A) <u>Pulmonary edema</u> (B) <u>Uremia</u> (C) <u>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>48-72 hrs.</u> <u>10 years</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Electrolyte imbalance</u>					19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>NO</u>				
20A. AUTOPSY? (Yes or No) <u>NO</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>65</u> to <u>1/16</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE <u>Donald Rice</u>					23B. DATE SIGNED <u>1/16/65</u>				
23A. SIGNATURE <u>Donald Rice</u>					23B. DATE SIGNED <u>1/16/65</u>					23C. PHYSICIAN'S NAME (Type) <u>Donald Rice</u>				
23C. PHYSICIAN'S NAME (Type) <u>Donald Rice</u>					23D. ADDRESS <u>Sinai Hospital</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>1/17/65</u>					24C. NAME OF CEMETERY or CREMATORY <u>Beth Tfiloh Cong.</u>				
24B. DATE <u>1/17/65</u>					24C. NAME OF CEMETERY or CREMATORY <u>Beth Tfiloh Cong.</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>					25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 Reist Rd.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

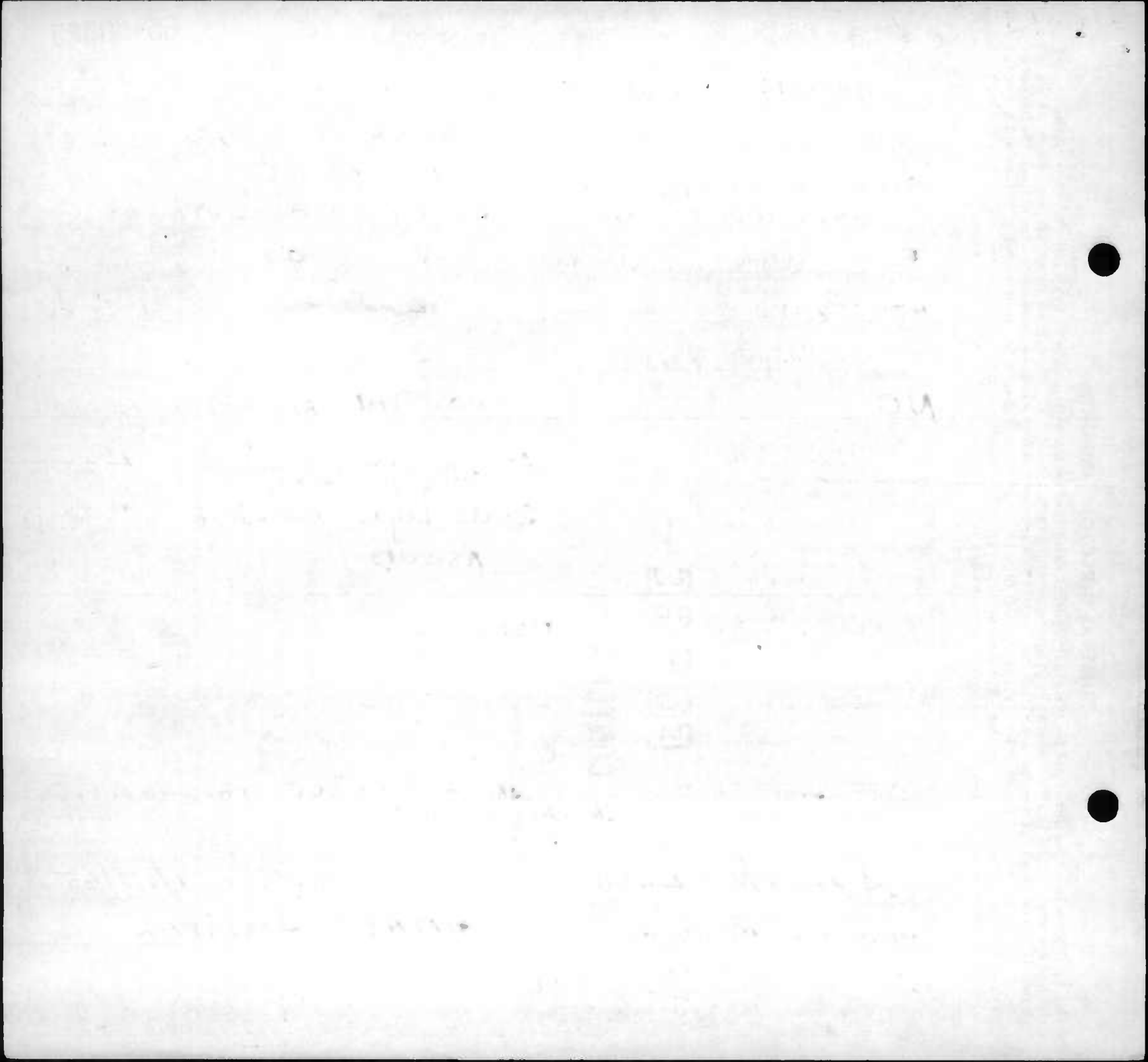
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0624				
BIRTH NO. 65 0624					2. DATE AND HOUR OF DEATH January 16, 1965 12:05 a.m.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Benjamin Hopkins					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 11-02				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore					D. STREET ADDRESS (If rural, give location) 1111 Park Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 5/23/03	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail		10B. KIND OF BUSINESS OR INDUSTRY Grocer		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Judah E. Hopkins				14. MOTHER'S MAIDEN NAME Hannah Rabinowitz					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-34-9766		17. INFORMANT ADDRESS David Hopkins - 234 S. Broadway				
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 day				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Lymphosarcoma (B) DUE TO					11 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from January 15, 1965 to January 15, 1965, that (I) was last saw the deceased alive on January 16, 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.									
23A. SIGNATURE Harry M. Charkatz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-16-65		
23C. PHYSICIAN'S NAME (Type) Harry M. Charkatz				23D. ADDRESS Sinai Hospital of Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/1965		24C. NAME OF CEMETERY or CREMATORY Beth Jacob		24D. LOCATION (City, town, or county) (State) Finksburg, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc.			ADDRESS 6010 Reisterstown RD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

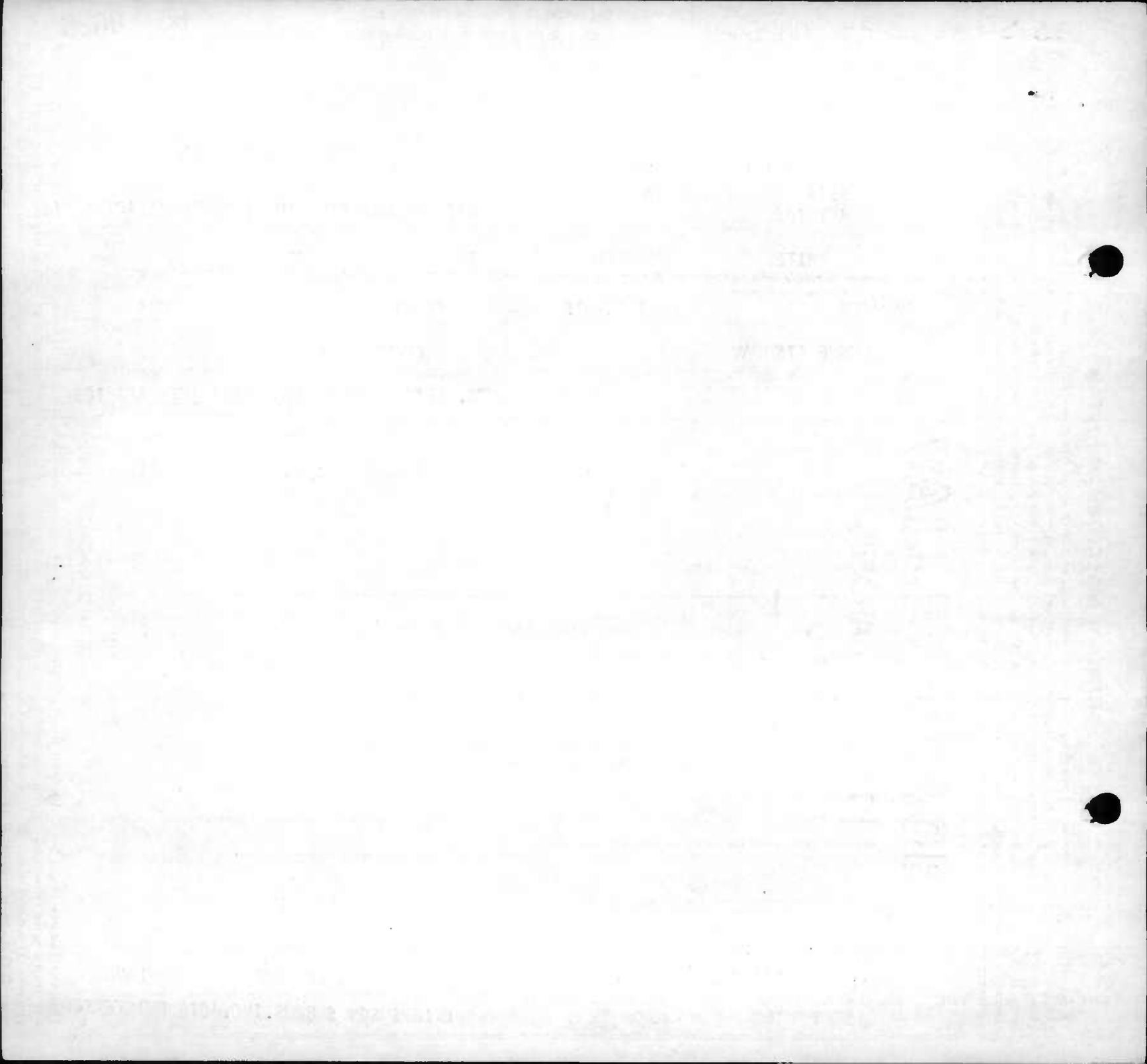
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 0625</u>	
BIRTH NO. <u>65 0625</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BESSIE GROLLMAN</u>		2. DATE AND HOUR OF DEATH <u>1/17/65</u> <u>9 18</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INC.</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>15-13</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>2608 LOYOLA SOUTHWAY</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>94</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NAHUM KARN</u>				14. MOTHER'S MAIDEN NAME <u>ETTA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HOSPITAL ADMISSION RECORD</u>			
18. <u>420.11</u>		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Acute pulmonary edema + congestive heart failure</u>				<u>4 days</u>	
ANTECEDENT CAUSES		(B) <u>Acute Myocardial Infarct</u>				<u>4 days</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>ASCVD</u>					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>Uremia</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>JANUARY 13, 1965</u> to <u>JANUARY 17, 1965</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 17, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Samuel Muher</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/17/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>SAMUEL MUHER</u>				23D. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/18/65</u>		24C. NAME of CEMETERY or CREMATORY <u>ANSHE EMUNAH AITZ CHAIM</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>JAL KENNISON & Sons, Inc. 6010 Kennerston Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

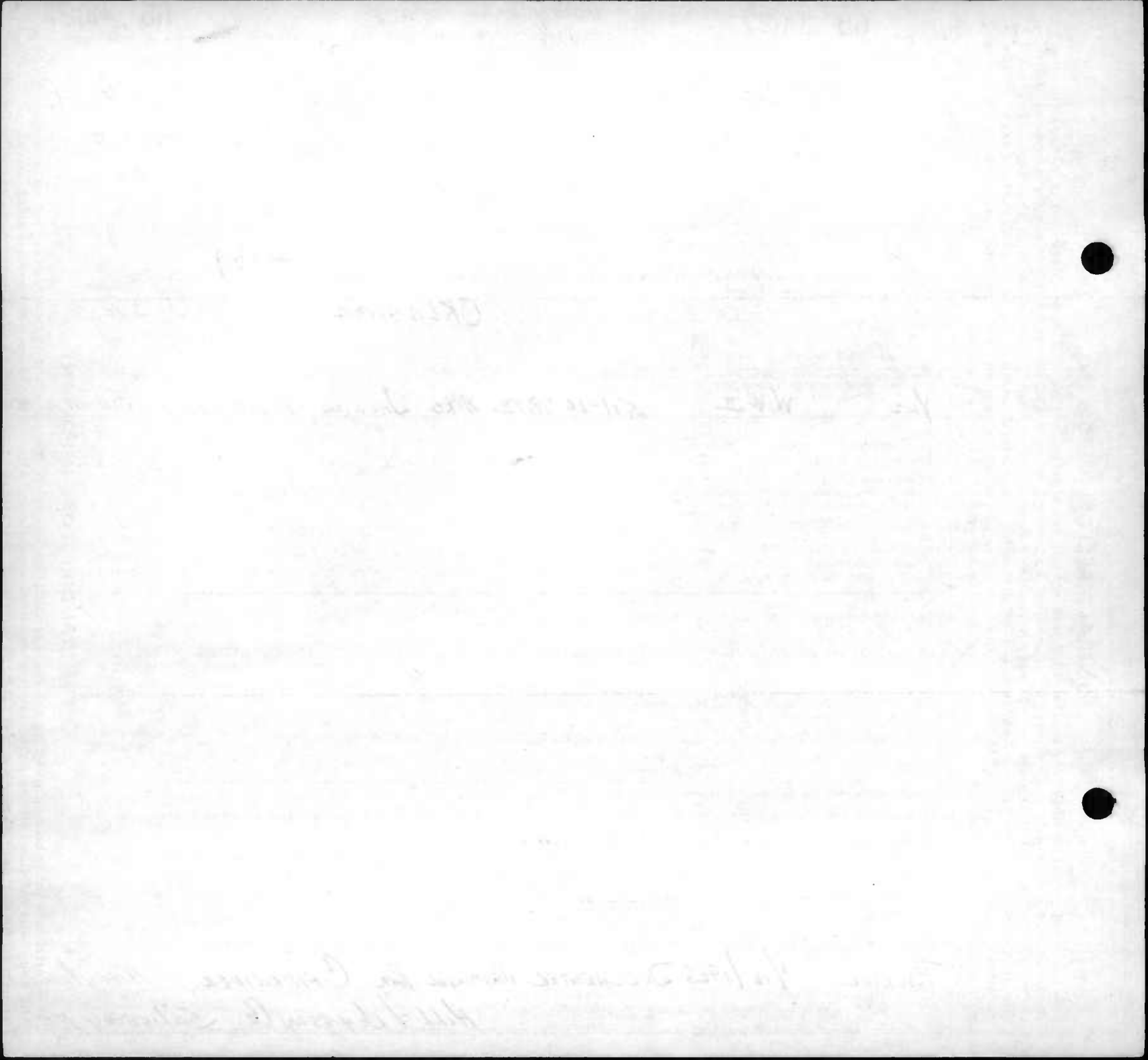
BIRTH NO. 65 0626				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0626	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DAVID FISHMAN				2. DATE AND HOUR OF DEATH Jan 16 1965 8:11 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) AMERICANA LANDMARK APTS 6316 GREENSPRING AVE APT 108				A. STATE MARYLAND B. COUNTY 27-20			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 6316 GREENSPRING AVE (AMERICANA APTS) #108			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1899	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MOSHE FISHMAN				14. MOTHER'S MAIDEN NAME CHAVE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ETTA FISHMAN AMERICANA APTS APT 108 6316 GREENSPRING AVE			
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Hypertensive C.V.D. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Cerebral Vascular Disease		2 yr.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 1964 to Jan 16 1965, that (I) (we) last saw the deceased alive on Jan 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph B. Gross M.D.				23B. DATE SIGNED Jan 16 1965			
23C. PHYSICIAN'S NAME (Type) Joseph B. Gross M.D.				23D. ADDRESS 6911 Park Heights Ave Baltimore MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/18/65		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		25D. ADDRESS 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

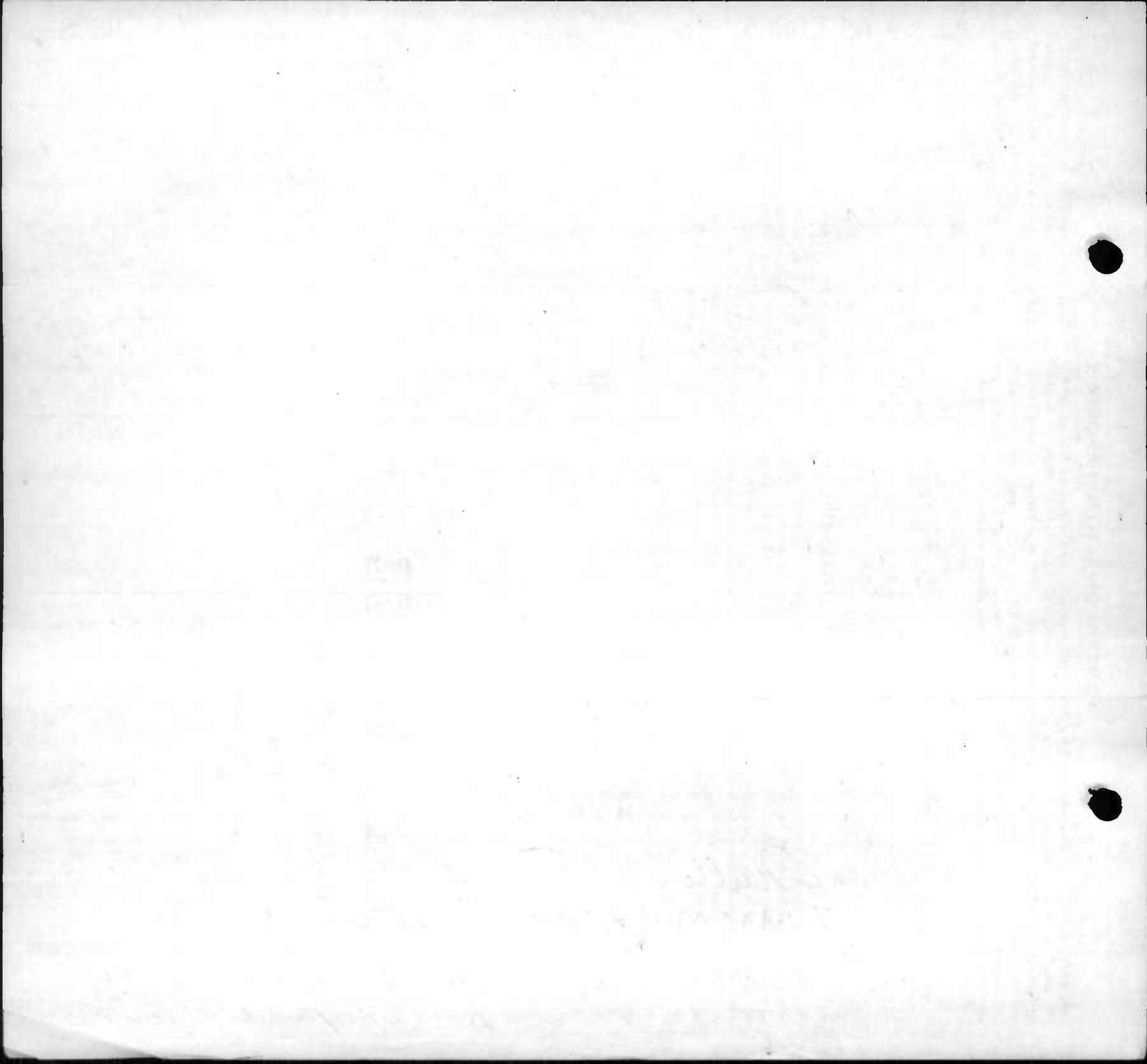
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0627	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 0627 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) WAYNE A. CLOUD			2. DATE AND HOUR OF DEATH 1.14.65 at 6^{PM} 6 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, MARYLAND			A. STATE Maryland B. COUNTY Wicomico		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Salisbury		
			D. STREET ADDRESS (If rural, give location) 610 Short St.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/19/05	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump Builder		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OKLAHOMA	
13. FATHER'S NAME Andrew Cloud			14. MOTHER'S MAIDEN NAME Pearl Beck		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) YES WWII		16. SOCIAL SECURITY NO. 511-10-9372		17. INFORMANT MRS. LAUNITA P. BRADLEY	
				ADDRESS VIENNA, MD	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Left carotid artery occlusion DUE TO (B) _____ DUE TO (C) _____		
			INTERVAL BETWEEN ONSET AND DEATH 5 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1.7.65 19 to 1.14 19 65 , that (I) (we) last saw the deceased alive on 1.14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE Thavatchai Fuangvudhiran				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) THAVATCHAI FUANGVUDHIRAN				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/16/1965		24C. NAME OF CEMETERY or CREMATORY DORCHESTER Memorial Park	
24D. LOCATION (City, town, or county) (State) Cambridge, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Hill & Johnson Co.	
				ADDRESS Salisbury MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0628				
BIRTH NO. 65 0628									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) FRANCIS LESTER HOLL					2. DATE AND HOUR OF DEATH 1-13-65				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 817 Pontiac Hous.					A. STATE Md. B. COUNTY 25-04				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location) 817 Pontiac Hous.									
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 1-23-15	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY Barto City		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME James			14. MOTHER'S MAIDEN NAME Katherine's Riley						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Family - Same				
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Arteriosclerosis DUE TO cardiovascular (B) disease DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 2 years	
					II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Pulmonary Oedema				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from January 13, 1963 to January 13, 1965 , that (I) (we) last saw the deceased alive on 1/13/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Francis Muller MD					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type) T SAAC MILLER MD					23D. ADDRESS 1225 So Charles St				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-18-65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore			
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS McCarty - 130 E Fort Ave				



41-55-83
FR

BALTIMORE CITY HEALTH DEPARTMENT

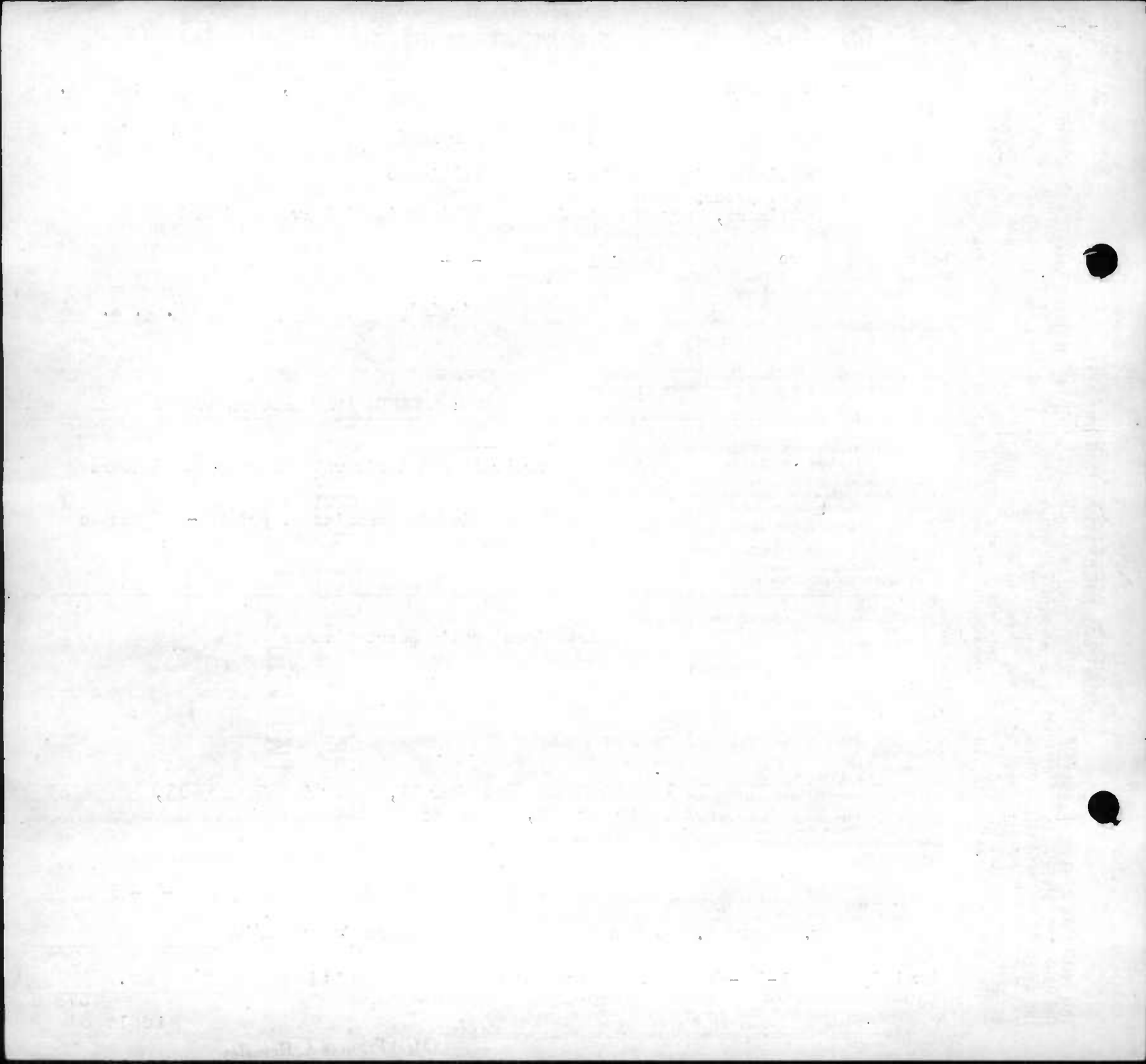
CERTIFICATE OF DEATH

Registered No. 65 0629

BIRTH NO. 65 0629		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Archie Tolson		2. DATE AND HOUR OF DEATH January 13, 1965 2:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1514 Druid Hill Avenue 21217	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-10-1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 62
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS BCH: RECORDS 4940 Eastern Avenue 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 151X I CAUSE OF DEATH (A) Cerebral Metastasis with Hemorrhage 2 Hours DUE TO (B) Metastatic Adenocarcinoma, Primary 5 Months DUE TO Stomach (C) INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from September 11, 1964 to January 13, 1965, that (I) (we) last saw the deceased alive on January 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Howard K. Rathbun		23B. DATE SIGNED 1-13-65	
23C. PHYSICIAN'S NAME (Type) Dr. Howard K. Rathbun		23D. ADDRESS M.D. 4940 Eastern Avenue 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-18-65	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cen	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.	25C. FUNERAL DIRECTOR Address 578 W Biddle St (Mrs) Frances A. Hemsley

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



H56265 0630

BALTIMORE CITY HEALTH DEPARTMENT

X CERTIFICATE OF DEATH

Registered No. 65 0630

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Anna Henrikson

2. DATE AND HOUR OF DEATH

1-14-65 1 6:15 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTIONBaltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 Choptank Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

2-13-90

9. AGE (In years
last birthday)

74

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Tebens

14. MOTHER'S MAIDEN NAME

UNK -

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

316-05-8136

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue

18.

170X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Respiratory

(A) Respiratory Failure
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

1 month

(B) Metastatic Lung Disease
DUE TO

?

(C) Carcinoma of Breast

16 months

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Multiple Metastases

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-12- 19 65 to 1-14- 19 65,
that (I) (we) last saw the deceased alive on 1-14- 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-14-65

23C. PHYSICIAN'S
NAME (Type)

Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/18/65

24C. NAME OF CEMETERY or CREMATORY

Balto Cemetery

24D. LOCATION

(City, town, or county)

(State)

North Ave - Balto. Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1965

25B. NAME OF REGISTRAR

Robert E. Fabela

25C. FUNERAL DIRECTOR

Joseph M. Zoumalis 263 S. Clarke

ADDRESS

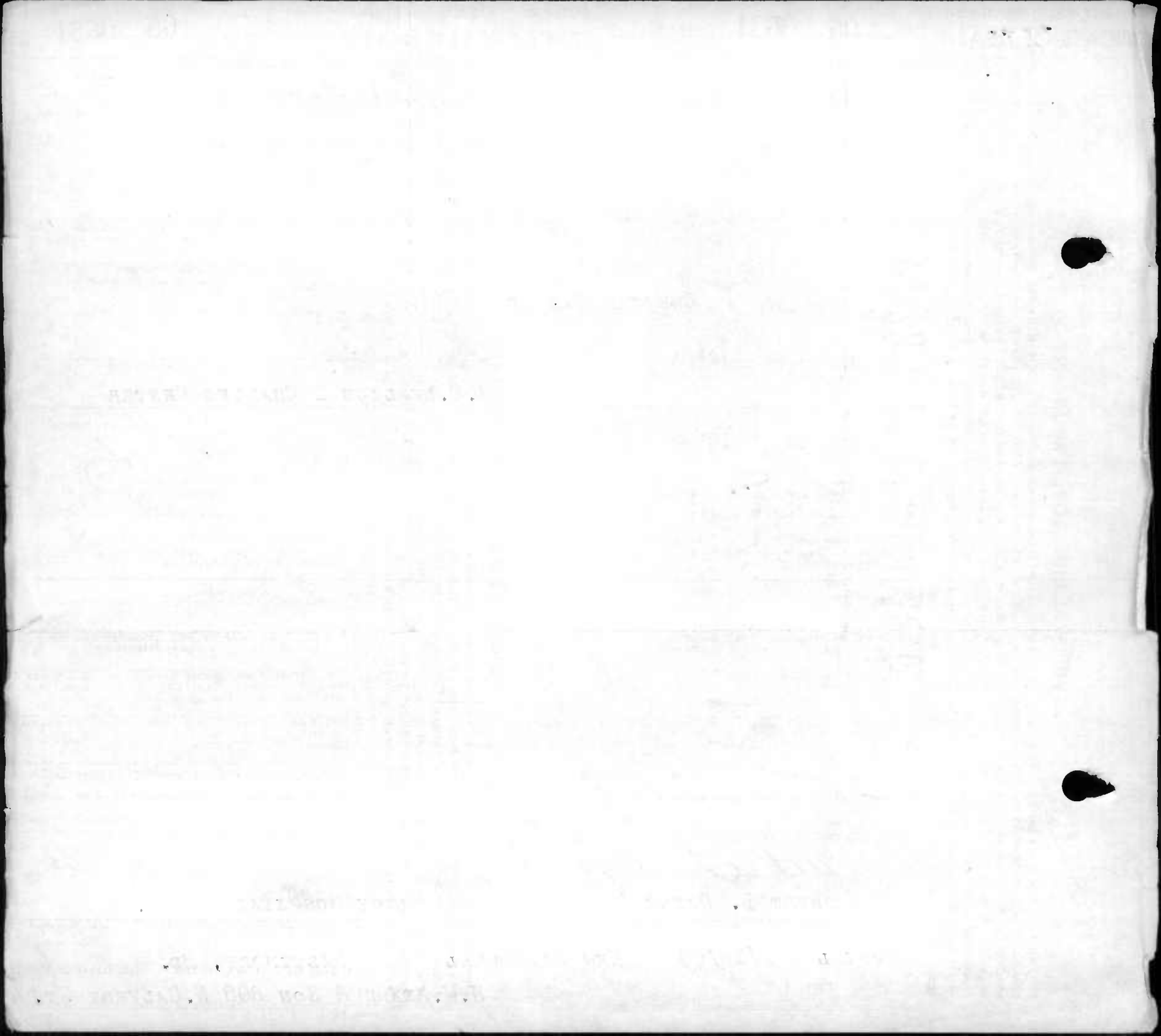
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

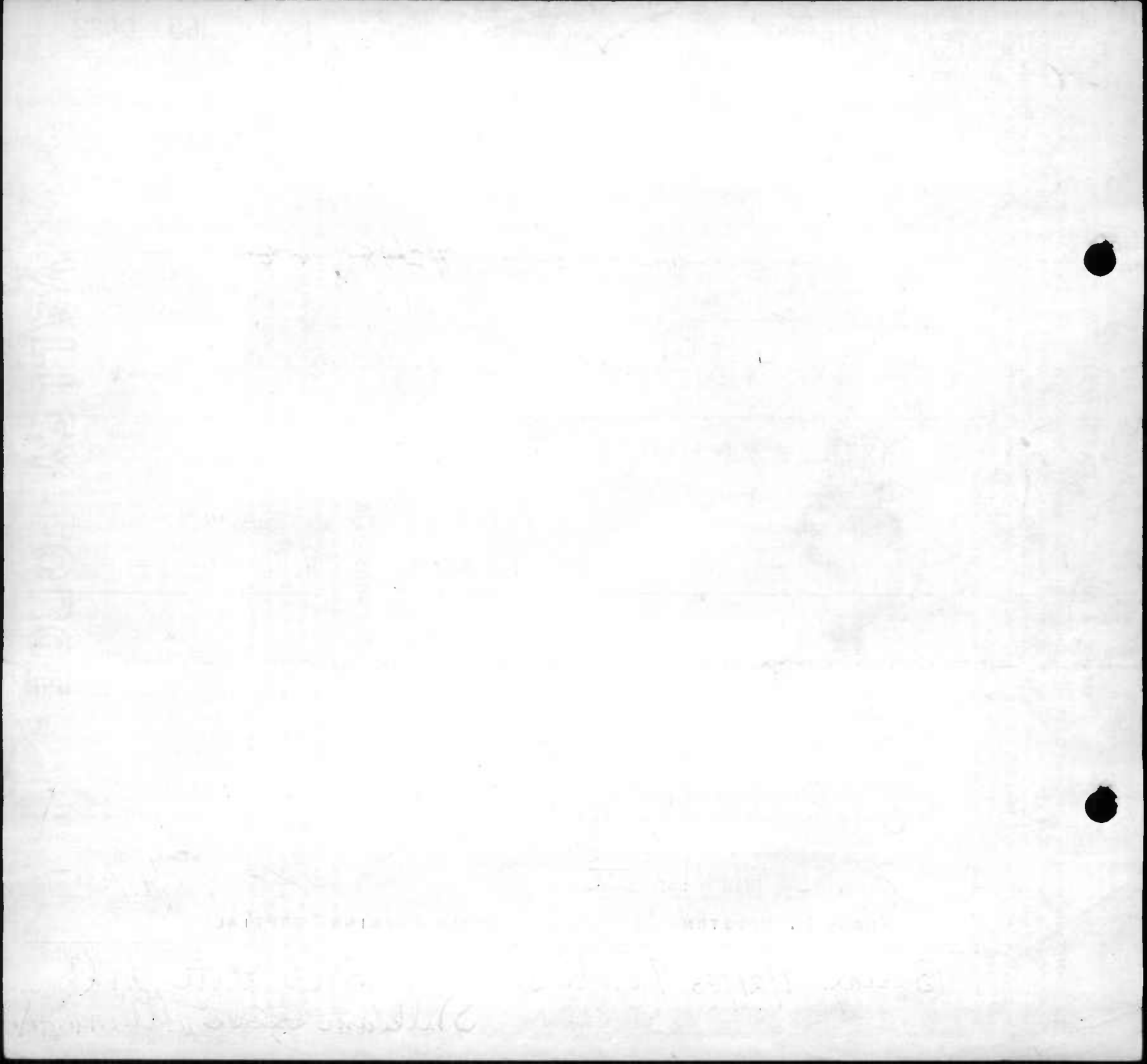
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0631	
BIRTH NO. 65 0631				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Robert Cook				1-14-65 1945 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital - Baltimore		(If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY 7-05	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver -		10B. KIND OF BUSINESS OR INDUSTRY CHECKER CAB CO		8. DATE OF BIRTH 4-8-13	
13. FATHER'S NAME Samuel Cook		14. MOTHER'S MAIDEN NAME Lilla Perry		9. AGE (In years last birthday) 51	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Ohio	
17. INFORMANT J.C. EVELIUS 1 CHARLES CENTER		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
18. 154X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Bilateral Pneumonia		1 day	
ANTECEDENT CAUSES		(B) Drunkening Septicemia		2-3 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hypotension & Clotting Imbalance Ca. of Death			
19A. DATE OF OPERATION 1-8-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of Death		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that he (This hospital) attended the deceased from 12-26-1965 to 1-14-1965 , that we (we) last saw the deceased alive on 1-14-1965 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE Robert L. Doyle				23B. DATE SIGNED 1-15-65	
23C. PHYSICIAN'S NAME (Type) ROBERT L. DOYLE				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/19/65		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL	
24D. LOCATION (City, town, or county) BALTIMORE, MD.		24E. STATE BALTIMORE, MD.		24F. ADDRESS H.W. MEARS & SON 805 N. CALVERT ST.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.	



FUNERAL DIRECTOR: IMPORTANT

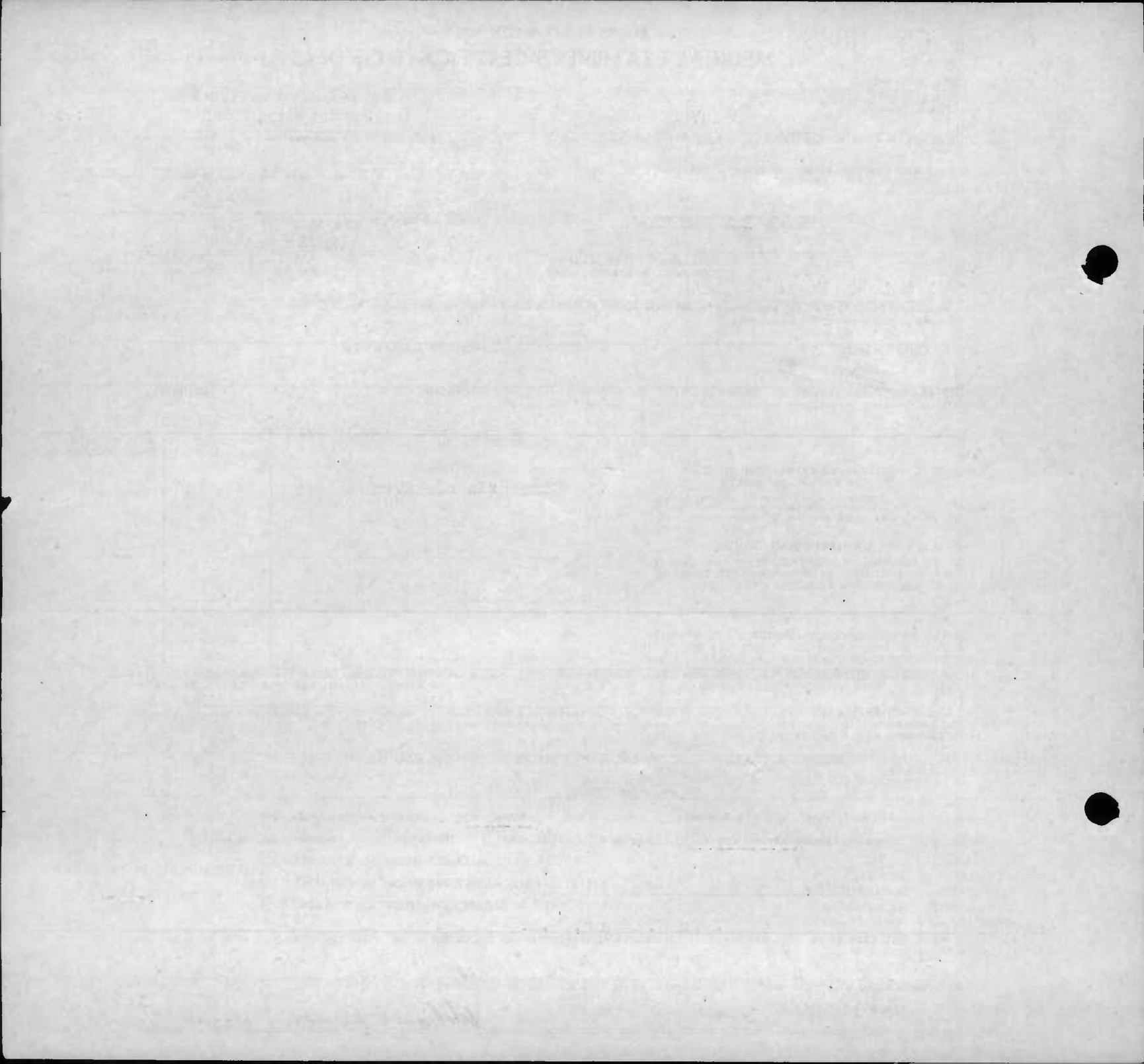
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0632	
BIRTH NO. 65 0632							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Frances Hall				2. DATE AND HOUR OF DEATH 1/17/65 11:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		A. STATE Md		B. COUNTY Anne Arundel	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis 52-10			
				D. STREET ADDRESS (If rural, give location) 520 Third			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 7/2/98	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Johnson				14. MOTHER'S MAIDEN NAME Susan Betts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 171X I Metabolic Alkalosis				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Pyloric Obstruction			
				(C) Metastatic Adenocarcinoma of cervical stump			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 12/19 19 64 to 1/17 19 65, that (1) (we) last saw the deceased alive on 1/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank M. Houston				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) FRANK M. HOUSTON				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/65		24C. NAME OF CEMETERY or CREMATORY Fowlers		24D. LOCATION (City, town, or county) (State) Best Gate, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR William Reese, II - Annap. Md.			



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BIRTH NO.
M.E. CASE NO. 59328BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0633

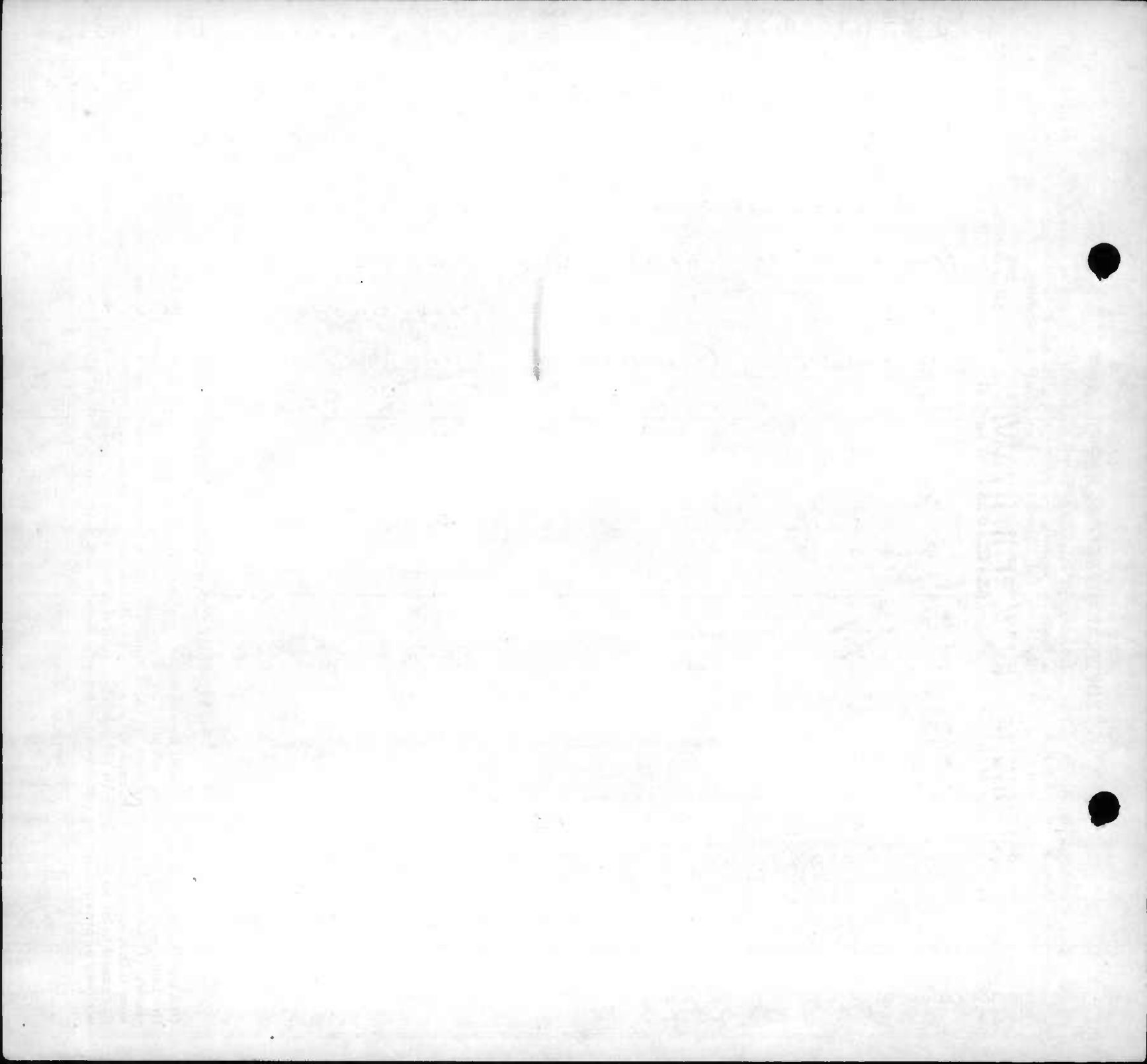
1. NAME OF DECEASED (Type or Print) DAISY STUBBS				2. DATE AND HOUR PRONOUNCED DEAD January 15, 1965 6:15 ^A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 17-01 D. STREET ADDRESS (If rural, give location) 667 W. Franklin Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH April 19, 1915	9. AGE (In years last birthday) 49	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Sumter S.C.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME David		14. MOTHER'S MAIDEN NAME Sadie Morgan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-7836		17. INFORMANT Thomas Poe Jr. 1922 W. Franklin St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John E. Adams M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-15-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Jan 20, 1965		23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. Balto. Md.			
24A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR William S. Funeral Home			
				ADDRESS 319 N Schroeder ST			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

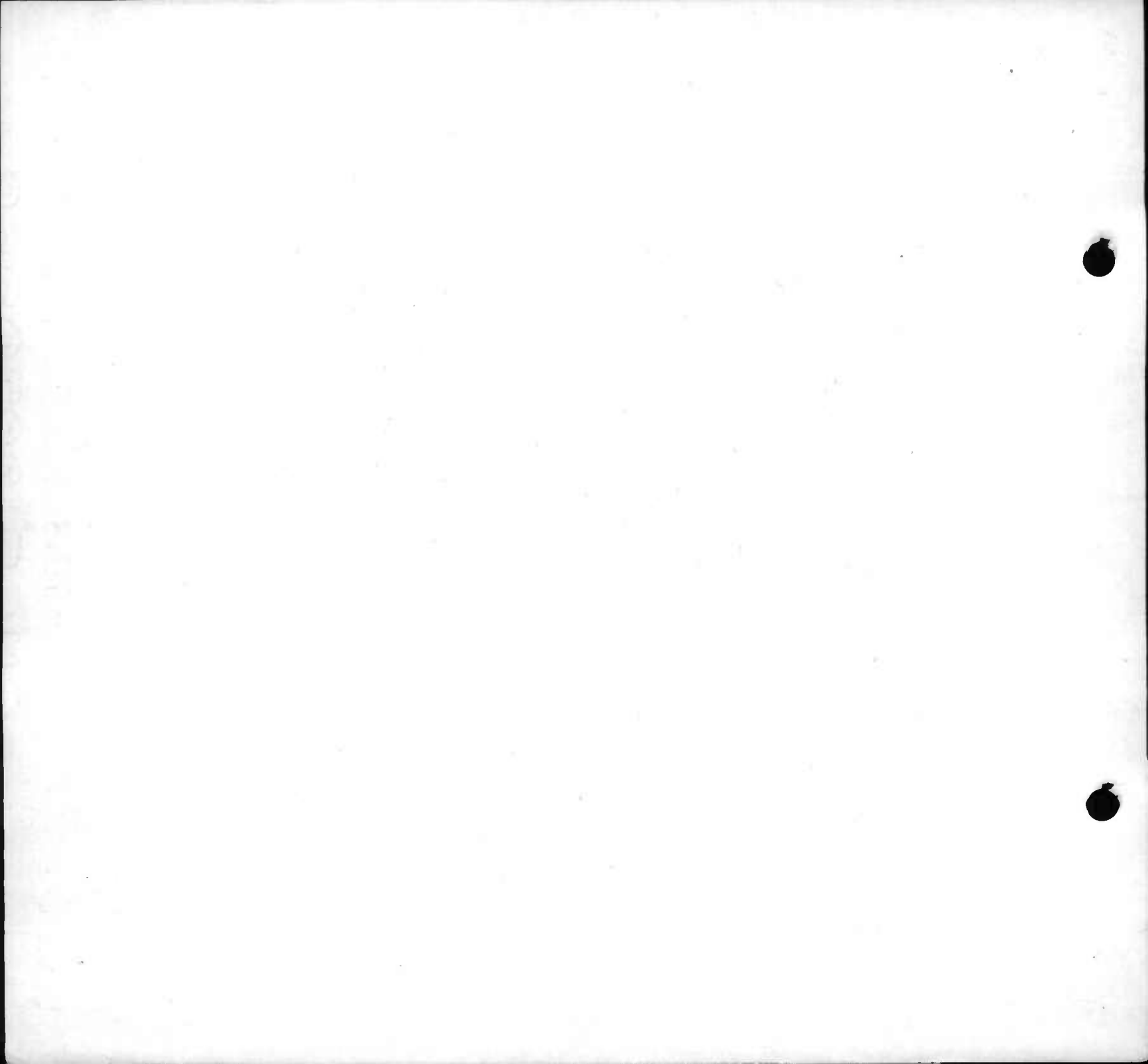
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0634	
CERTIFICATE OF DEATH					
BIRTH NO. G 263 65 0634		M.E. CASE NO. MARG ROSE GUCKERT			
1. NAME OF DECEASED (Type or Print) Mary Rose Guckert			2. DATE AND HOUR OF DEATH JAN 18/1965 12:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Hospital for The Women of Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 6. STREET ADDRESS (If rural, give location) 6921 Broening Rd.		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 7-24-1882	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown John Guckert		
14. MOTHER'S MAIDEN NAME unknown Josephine Funk			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT Mr. Christopher J. Guckert		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH Intra-aortic Atherosclerosis			19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 2			21. DATE OF OPERATION 2		
22. CONDITION FOR WHICH OPERATION WAS PERFORMED 2			23. AUTOPTSY? (Yes or No) yes		
24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 26. TIME OF INJURY (APPROX.)			27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 28. INJURY OCCURRED		
29. HOW DID INJURY OCCUR? While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			30. I certify that (I) (this hospital) attended the deceased from JAN 13/1965 to JAN 18/1965 , that (I) (we) last saw the deceased alive on JAN 18/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
31. SIGNATURE Dr. Kulkarni			32. DATE SIGNED 1-18-65		
33. PHYSICIAN'S NAME (Type) Dr. Kulkarni D.D.			34. ADDRESS Women's Hospital Baltimore Md.		
35. BURIAL CREMATION, REMOVAL (Specify) Burial			36. DATE 1/21/65		
37. NAME OF CEMETERY or CREMATORY Most Holy Redeemer			38. LOCATION (City, town, or county) (State) Baltimore, Maryland		
39. DATE REC'D BY HEALTH DEPT. JAN 19 1965			40. NAME OF REGISTRAR Robert E. Fisher		
41. FUNERAL DIRECTOR HENRY SANDER & SONS INC.			42. ADDRESS BALTO. MD.		



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THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

65 0635		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0635	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Janie Myers</i>			2. DATE OF DEATH <i>January 14, 1965</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1444 N. Bond St.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1444 N. Bond St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>1887</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>John Adams</i>			14. MOTHER'S MAIDEN NAME <i>Billie ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-09-8913</i>		17. INFORMANT <i>Family</i> ADDRESS <i>1444 N. Bond St.</i>	
18. <i>442X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Ch. Cardio-renal Vascular Disease</i> DUE TO (B) <i>Ch. Hypertension</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs.</i> <i>2 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-2-</i> <i>1965</i> to <i>1-16</i> <i>1965</i> , that (I) (we) last saw the deceased alive on <i>1-16</i> <i>1965</i> and that in (my) (our) opinion death occurred at <i>2 P.</i> m. from the causes and on the date stated above.					
23A. SIGNATURE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>Wm. L. Perry</i>		23B. ADDRESS <i>1237 N. Caroline</i>		23C. DATE SIGNED <i>1-19-65</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/21/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>A. A. County, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>		25C. FUNERAL DIRECTOR <i>Robert E. Williams, 1701-03 N. Bond St. 13</i>			



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65 0636 BALTIMORE CITY HEALTH DEPARTMENT 65 0636

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. X

M.E. CASE NO. 59347

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
RICHARD PRICE		1-18-65	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
6012 Flamingo Drive - Baltimore 21225		B. COUNTY a.a.c.	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		6012 Flamingo Drive - 21225	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	Colored	Never married	10-8-1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Laborer			69
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
A.A.C. Md		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lewis Price		Martha Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		215-05-9147	Campbell Howard - 6212 Flamingo Dr
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) 2nd and 3rd degree burns and Carbon Monoxide poisoning			
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	Home	6012 Flamingo Drive - Balto. 21225	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	Bed caught fire while smoking	
1 18 '65 7:00 AM			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
PETER W. RIECKERT, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED	
		1-18-65	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	10-21-65	Mt Calvary	Brooklyn Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 19 1965	Robert E. Farley, M.D.	Wernell S. Oden	Balto. Md

VS 151-REV. 1/1/65 N 948.2

WALLLEY & CO. BOSTON

THE OFFICE

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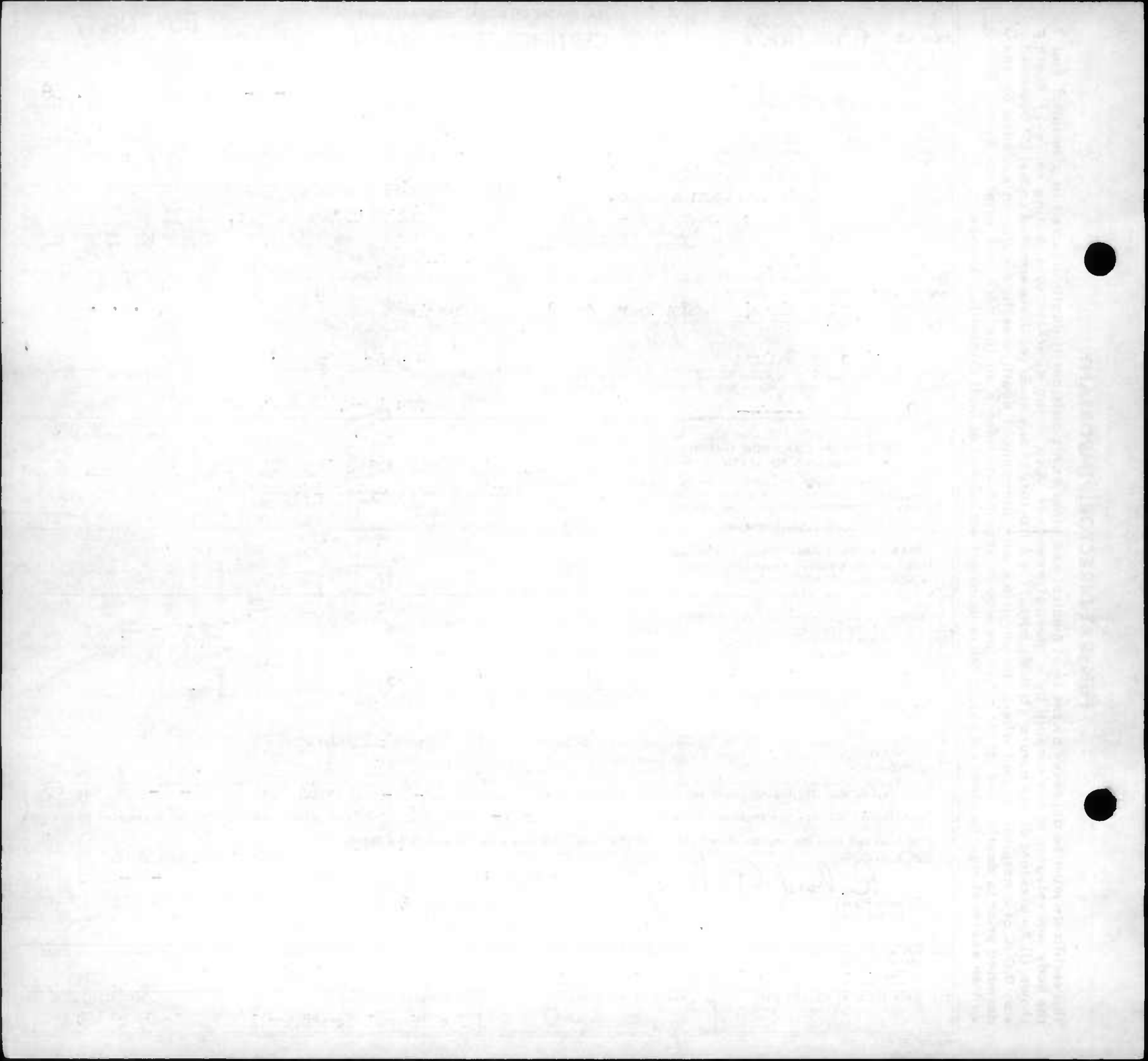
THE OFFICE

THE OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

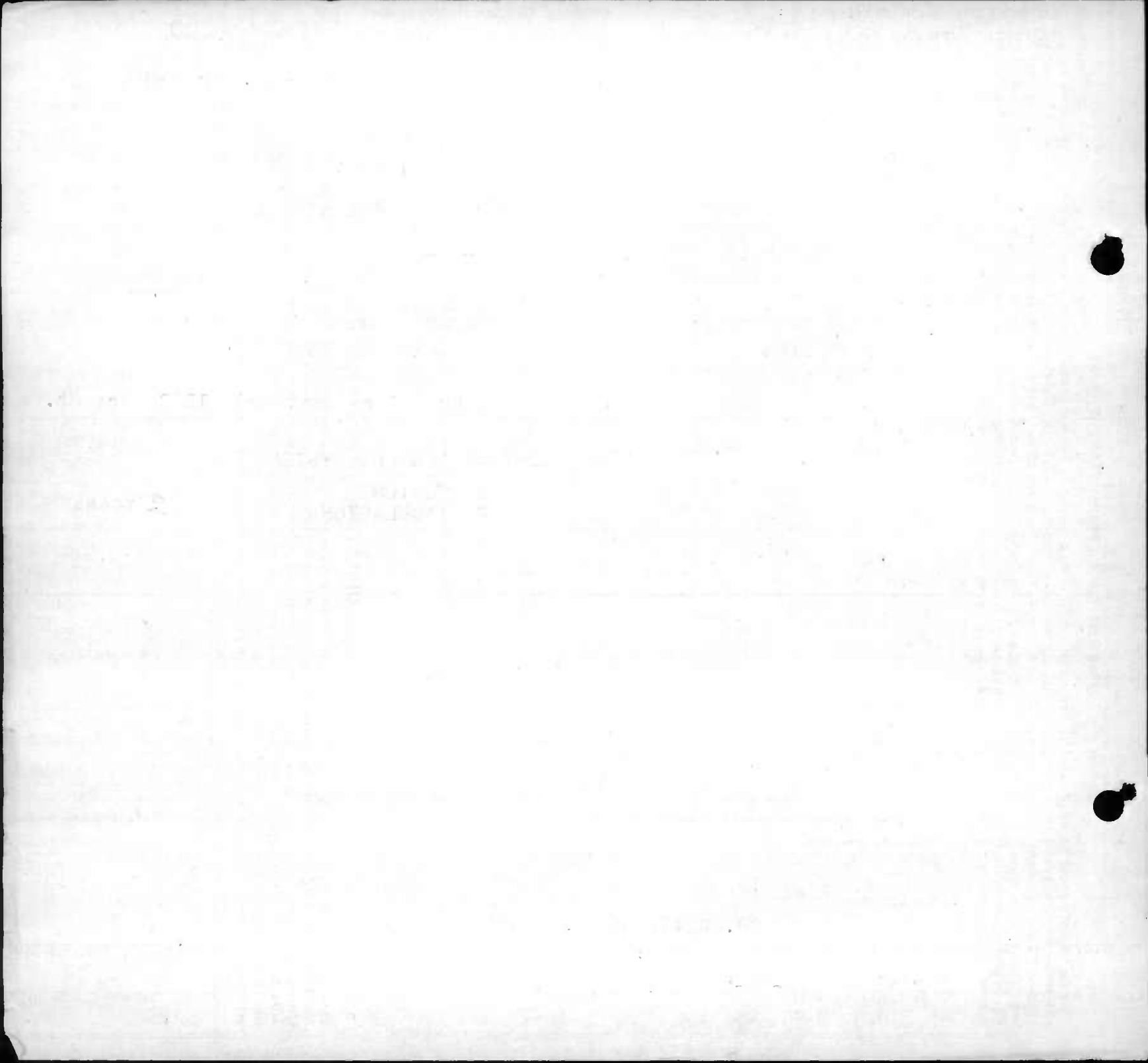
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0637	
BIRTH NO. 65 0637 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Alex Safron		2. DATE AND HOUR OF DEATH 1-17-1965 11.35A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland-21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 202 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 104 South Durham Street, 21231			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-24-1886	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Retired		10B. KIND OF BUSINESS OR INDUSTRY Southern Hotel		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Timothy Safron			14. MOTHER'S MAIDEN NAME Sophie Unk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 6666		17. INFORMANT Records: BCH-4940 Eastern Avenue ADDRESS	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) DUE TO Chronic Obstructive Lung Disease Arteriosclerotic Cardiovascular Disease (B) DUE TO (C) DUE TO </div> <div style="width: 45%;"> INTERVAL BETWEEN ONSET AND DEATH years </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-18- 19 64 to 1-17- 19 65 , that (I) (we) last saw the deceased alive on 1-17- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard A. Lane				23B. DATE SIGNED 1-17-1965	
23C. PHYSICIAN'S NAME (Type) Richard A. Lane			23D. ADDRESS 4940 Eastern Avenue 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 19 65		24C. NAME of CEMETERY or CREMATORY Holy Trinity Cemetery	
24D. LOCATION (City, town, or county) (State) Elkridge Md		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965 25B. NAME OF REGISTRAR Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR The Dippel Brothers 1800 E Lombard St ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

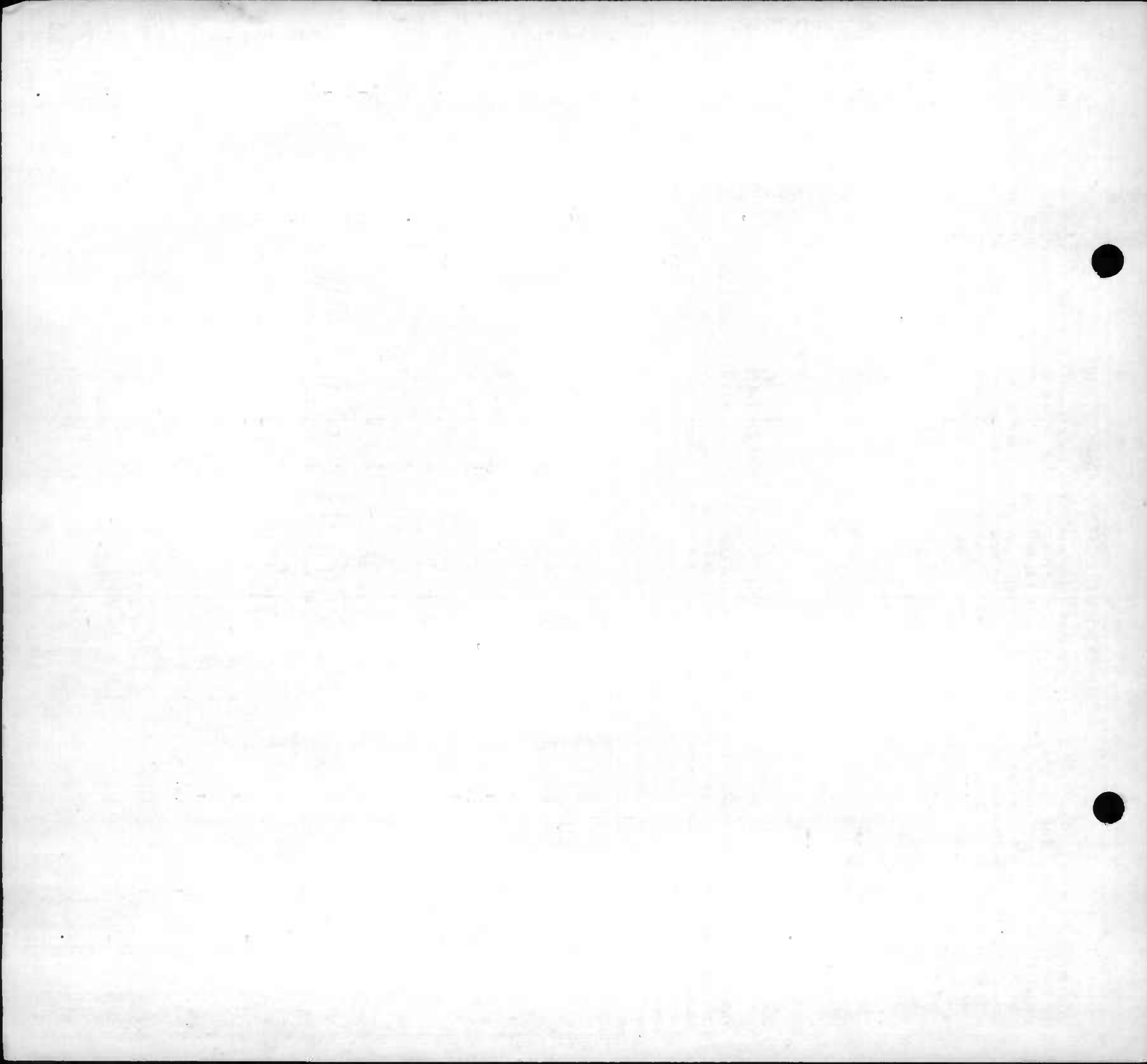
BIRTH NO. 552065 61-10878 0638		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0628	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
DARRELL ADAIR SIMS		1-16-65. 3:03 PM		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY 23-01	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		1103 RACE STREET	
5. SEX C	6. RACE MALE * MALE	7. MARRIED, NEVER MARRIED SINGLE	8. DATE OF BIRTH 4-12-61	9. AGE (In years last birthday) 3	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOHN SIMS		14. MOTHER'S MAIDEN NAME SUSAN CROWDER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John Sims (Father) 1103 Race St.	
18. 192x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CENTRAL NERVOUS SYSTEM ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO DEPRESSION RETINOBLASTOMA (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) Jan. 16, 1965 3:03 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 14 19 65 to January 16 19 65 . that (I) last saw the deceased alive on Jan. 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Keith R. McClosky		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan. 16, 1965	
23C. PHYSICIAN'S NAME (Type) DR. KEITH R. MCCLOSKEY		23D. ADDRESS JHH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE I-20-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore City		24E. STATE Maryland		24F. COUNTY 23-01	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Falek, M.D.		25C. FUNERAL DIRECTOR Isaiah L. Brown & Son	
25D. ADDRESS 108 W. Montgomery St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

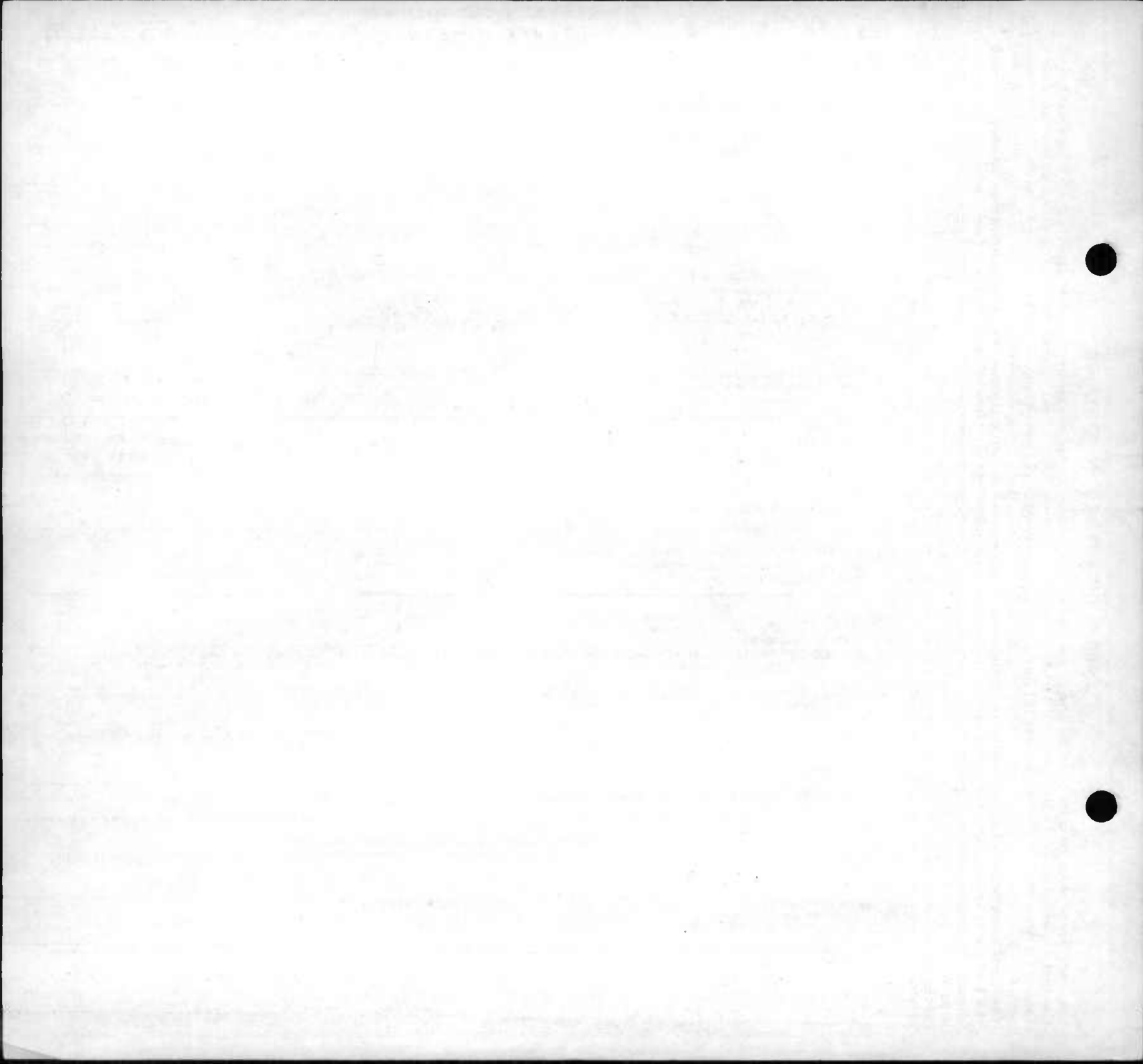
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0639	
BIRTH NO. 65 0639				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Emma Hayes</u>			2. DATE AND HOUR OF DEATH <u>1-15-65</u> <u>9:15 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1103 N. Carey Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>IDA MOORE 1103 N Carey St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebro-vascular accident</u> <u>Intra cerebral hemorrhage</u> <u>Severe hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis</u> <u>Malnutrition, secondary</u>					
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-27-64</u> 19 to <u>1-15-65</u> 19, that (I) (we) last saw the deceased alive on <u>1-15-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Asuncion P. Lazaro</u> M.D.				23B. DATE SIGNED <u>1-15-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Asuncion P. Lazaro</u>			23D. ADDRESS M.D. <u>1514 Division Street, Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burnt</u>		24B. DATE <u>1-18-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT AUBURN</u>	
24D. LOCATION <u>BALTO MD</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u> M.D.		25C. FUNERAL DIRECTOR ADDRESS <u>Maribeth A. Hughes 638 N Gilmore St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

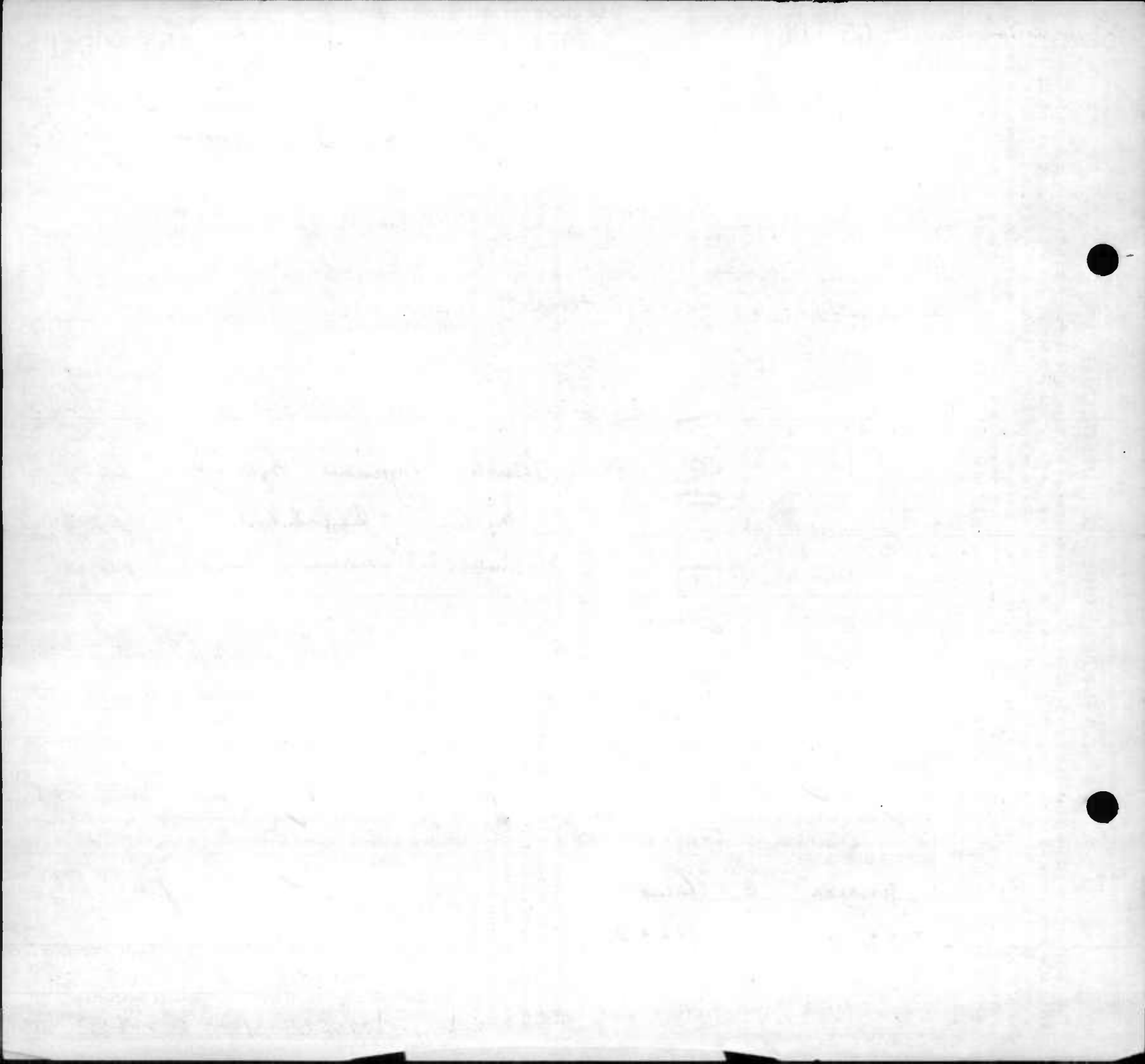
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 0640										Registered No. 65 0640	
CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print)		Smith, Franklin Otis				2. DATE AND HOUR OF DEATH		1/16/65 12:35 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital						A. STATE B. COUNTY Maryland, Carroll					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sykesville 56-00					
						D. STREET ADDRESS (If rural, give location) White Rock Road					
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Mar 3, 1908		9. AGE (In years last birthday) 56		(If Under 1 Yr. Months Days)		(If Under 24 Hrs. Hours Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver orderly				10B. KIND OF BUSINESS OR INDUSTRY Masonic Home		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Smith						14. MOTHER'S MAIDEN NAME Betty Tate					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-07-4463		17. INFORMANT MRS. Harriett Smith				ADDRESS Same as # 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 782.41 Cardiac failure						INTERVAL BETWEEN ONSET AND DEATH 2 Hours					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12:15 Jan 16 1965 to 12:35 AM Jan 16 1965, that (I) (we) last saw the deceased alive on 12:35 AM Jan 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE David W. Morse						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type) David W. Morse						23D. ADDRESS University Hospital, Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-1965		24C. NAME OF CEMETERY OR CREMATORY White Rock		24D. LOCATION (City, town, or county) (State) CARROLL Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965				25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR C.M. WATZ				ADDRESS Box 241, Sykesville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

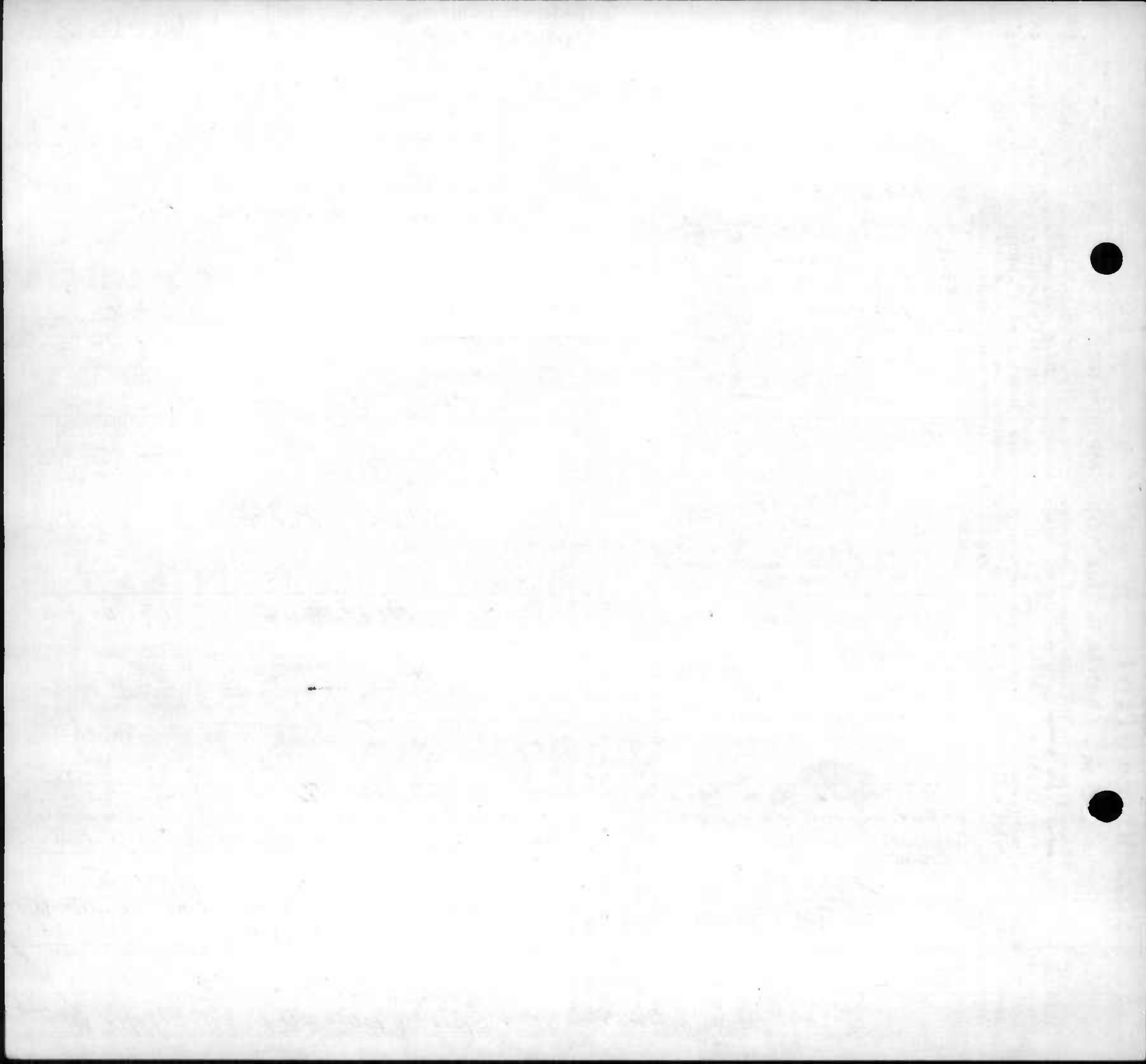
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0641</u>	
BIRTH NO. <u>65 0641</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FRIERS, ERNEST A.</u>			
2. DATE AND HOUR OF DEATH <u>1/18/65 9:00am</u>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>5909 ST. CHARLES AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-1-85</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NOT KNOWN Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas Electric Co</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ERNEST AUGUST FRIERS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>212-05-6510</u>		17. INFORMANT <u>Mrs. Marie Friers - 5909 Charles Ave.</u>	
18. <u>20.1 I</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Possible Myocardial Infarction</u>		<u>2 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(B) <u>Coronary Heart Failure</u>		<u>years</u>	
		(C) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>years</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>HE</u> (this hospital) attended the deceased from <u>Jan 16</u> 19 <u>65</u> to <u>Jan 18</u> 19 <u>65</u> , that <u>HE</u> (we) last saw the deceased alive on <u>9:00 AM Jan 18</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Zenaida C. Palao</u>				23B. DATE SIGNED <u>Jan 18, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>ZENaida C. PALAO</u>		23D. ADDRESS <u>Fayette St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/21/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John T. Stansbury</u>			
ADDRESS <u>6411 W. Windsor Mill Rd</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0642	
BIRTH NO. 65 0642							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) FREDA WESTERMAN				2. DATE AND HOUR OF DEATH 1/16/65 5.50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVINDALE HEBREW HOME & INFIRMARY				A. STATE MARYLAND			
				B. COUNTY 27-17			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
				D. STREET ADDRESS (If rural, give location) GREENSPRING + BELVEDERE AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 73	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELIA				14. MOTHER'S MAIDEN NAME GITTLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSP RECORDS		ADDRESS	
18. 420.0 + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) BRONCHOPNEUMONIA DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETES MELLITUS		NOT KNOWN	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 1/16/1965 to 12/12/1964 that (A) (we) lost saw the deceased alive on 1/16/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George Bercu, M.D.				23B. DATE SIGNED 1/16/65			
23C. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU				23D. ADDRESS LEVINDALE HEBREW HOME & INFIRMARY BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/18/1965		24C. NAME OF CEMETERY or CREMATORY ROSEDALE		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & Son		ADDRESS 3319 OLYMPIA AVE	



1
M. 200

65 0643

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 0643

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NORRIS MACK (Philmore)

2. DATE AND HOUR PRONOUNCED DEAD

1-18-65

5:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2335 Eutaw Place

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

May 5, 1932

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Mack

14. MOTHER'S MAIDEN NAME

Agnes Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

2/2/53- 1/12/56

16. SOCIAL
SECURITY NO.

220-24-3455

17. INFORMANT

Mary Mack

ADDRESS

2335 Linden Ave.

18. E900.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1308 Stockton Street - Baltimore 21217

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

1 17 1965 3:50 AM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell Down basement steps

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/21/65

23C. NAME of CEMETERY or CREMATORY

Baltimore Natl. Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

N956.2 JAN 19 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

George H. Klam 1348 N. Calhoun St.

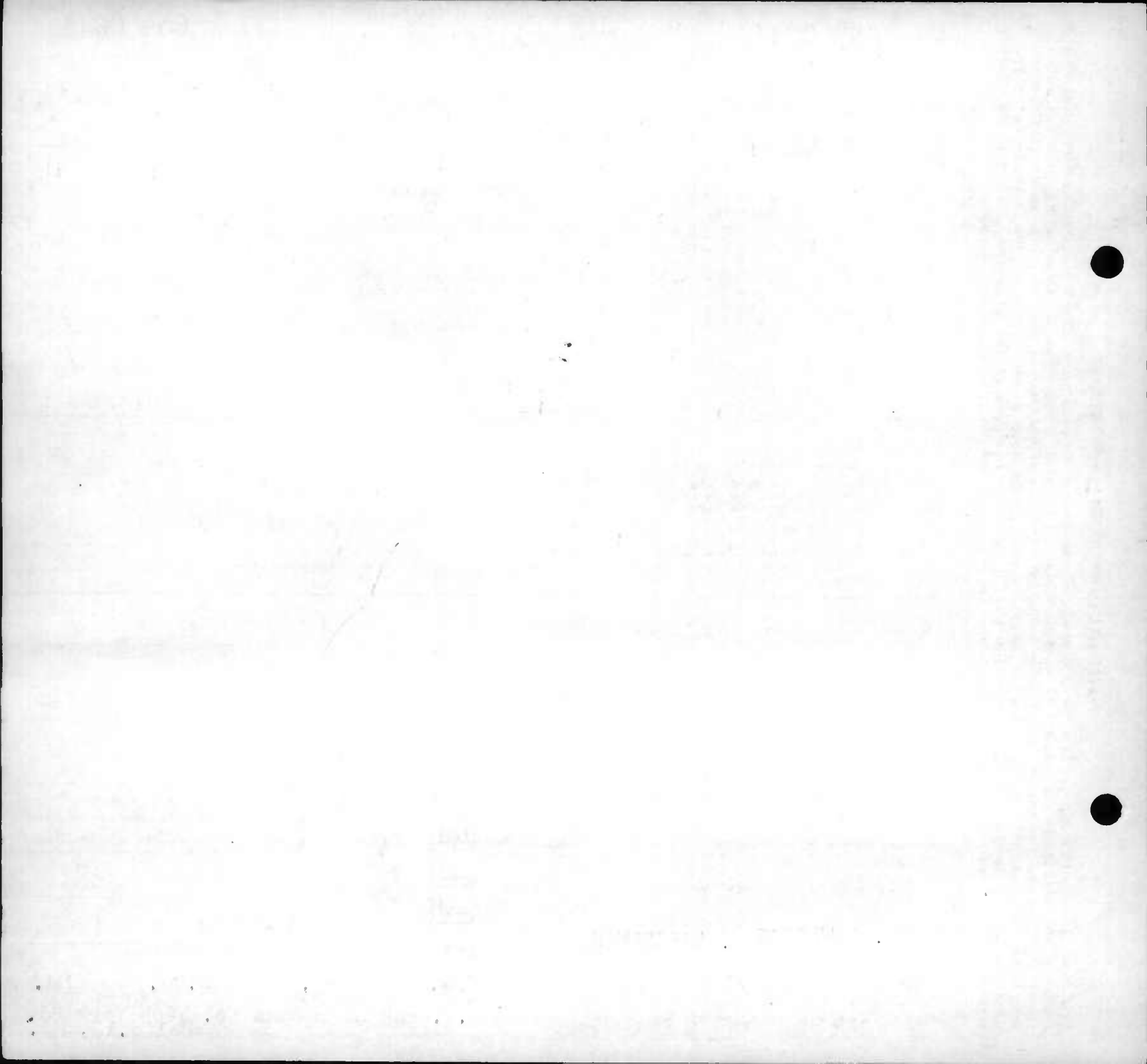
ADDRESS

WALLEY BRIDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

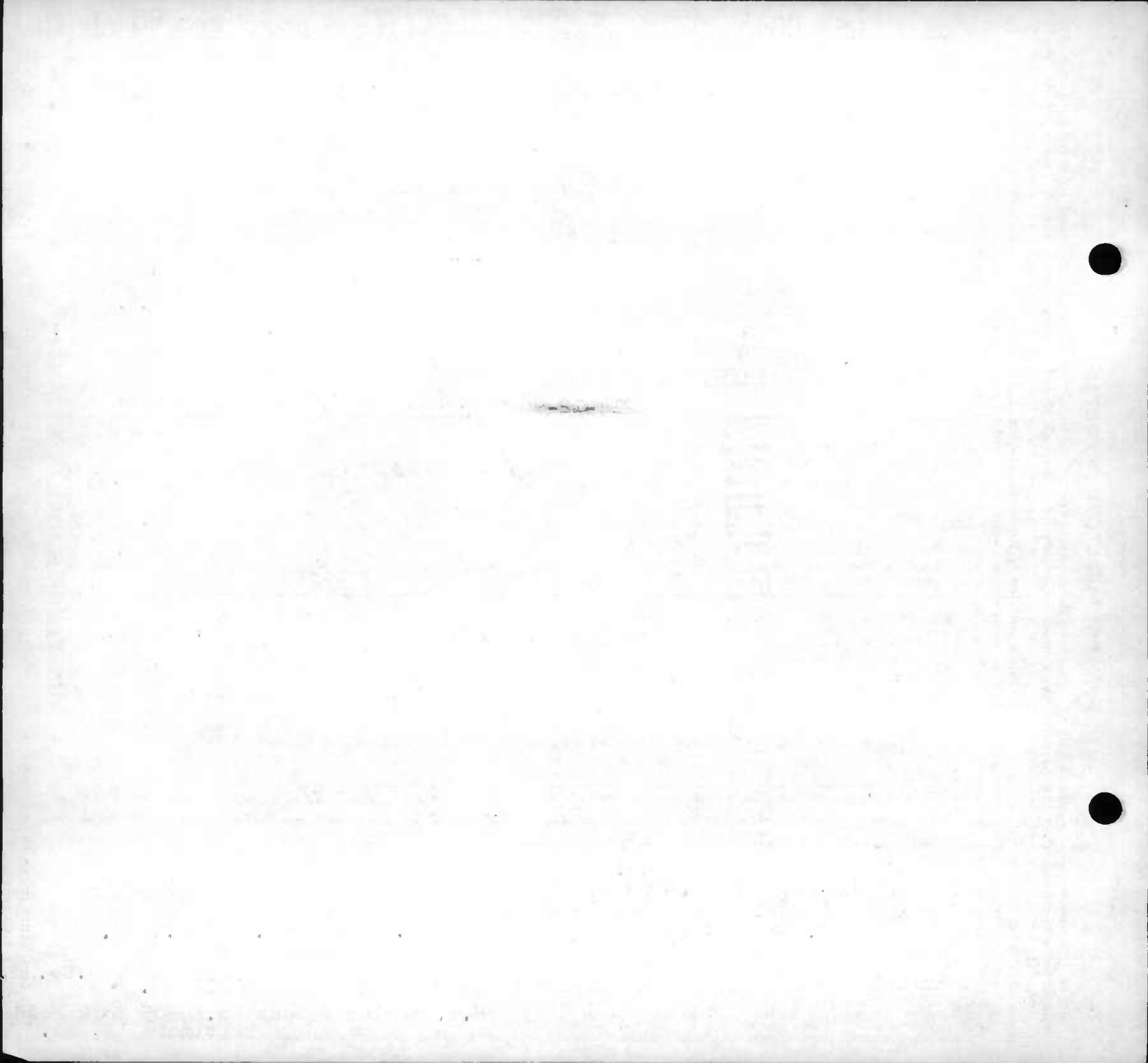
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0644	
BIRTH NO. 65 0644				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John Stanley Foard				2. DATE AND HOUR OF DEATH 1-17-65 7⁰⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 211 PADDINGTON Road	
5. SEX M	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-10-93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT		10B. KIND OF BUSINESS OR INDUSTRY SCHOEN - RUSSELL, INC.		11. BIRTHPLACE (State or foreign country) LONG GREEN, MARYLAND	
13. FATHER'S NAME FRANK T. FOARD			14. MOTHER'S MAIDEN NAME EMMA McComas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-03-3215		17. INFORMANT ADDRESS Chart - Union Memorial Hospital	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 65	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1-2 19 65 to 1-17 19 65 , that (2) (we) lost saw the deceased alive on 1-17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence J. Lieberman, M.D.				23B. DATE SIGNED 1-17-65	
23C. PHYSICIAN'S NAME (Type) DR. LAWRENCE J. LIEBERMAN			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/1965		24C. NAME OF CEMETERY OR CREMATORY Fork, Balto. Co., Md.	
24D. LOCATION Fork, Balto. Co., Md.		24E. NAME OF REGISTRAR Robert E. Farber, M.D.		24F. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

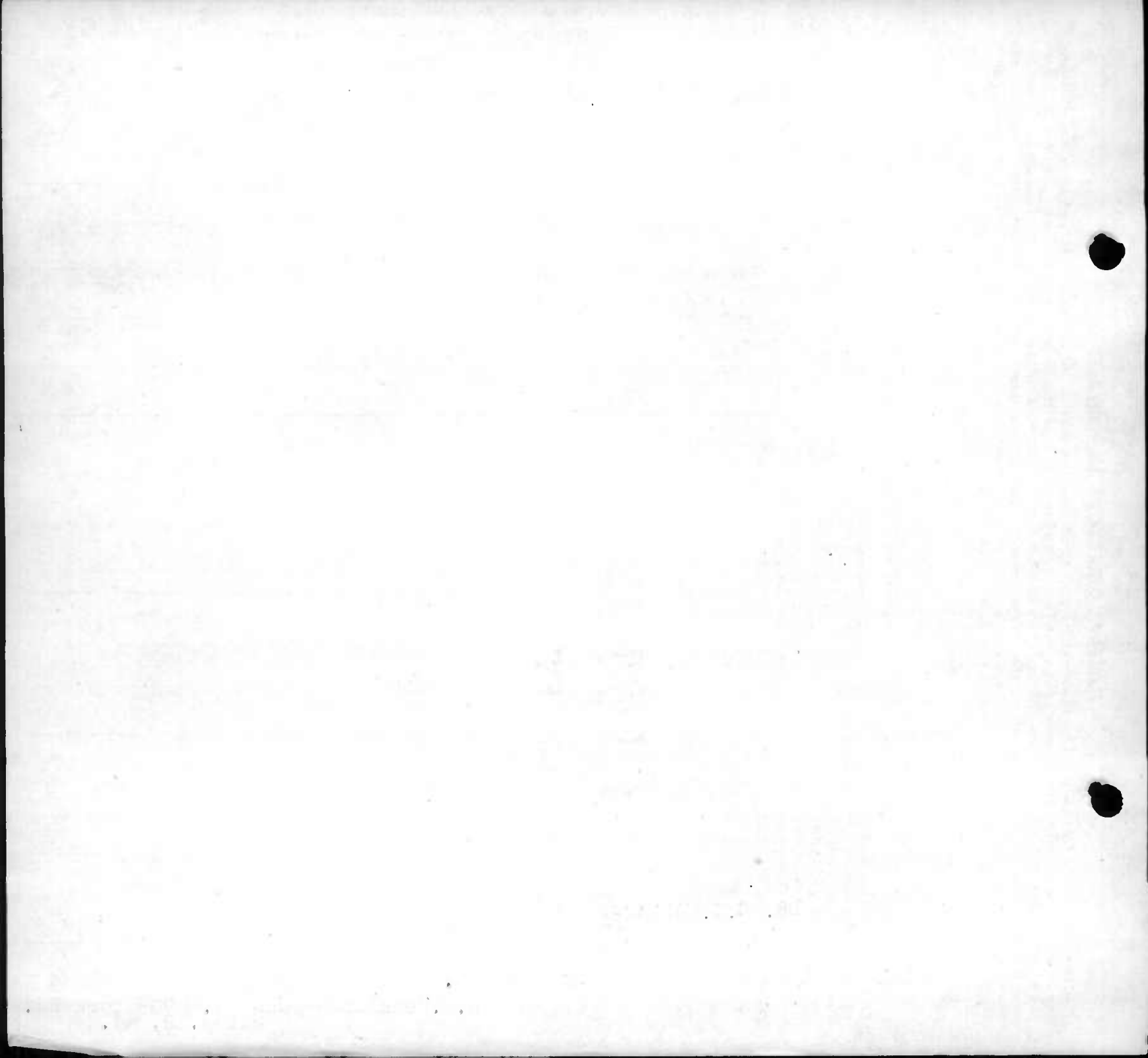
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 1001 65 0645	
BIRTH NO. 65 0645							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Zacharski, Casimir, Martin				2. DATE AND HOUR OF DEATH 1-16-65 10:25 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1000 Lenton Avenue			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) X	8. DATE OF BIRTH 3-4-1891	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edmund J. Zacharski			14. MOTHER'S MAIDEN NAME Julia Hoppe				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-9860		17. INFORMANT ADDRESS C.M. Zacharski, 1000 Lenton Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia				CAUSE OF DEATH (A) DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Septicemia				(B) DUE TO Septicemia		2 wks	
(C) Infected ischemic ulcer				(C) Infected ischemic ulcer		4 wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chronic brain syndrome						4 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from May 1 1961 to Jan 16 1965 , that (U) (we) last saw the deceased alive on Jan 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Raymond Gladue				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue				23D. ADDRESS 1000 S. Caton Ave. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/1965		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) 7300 Germanhill Rd. Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

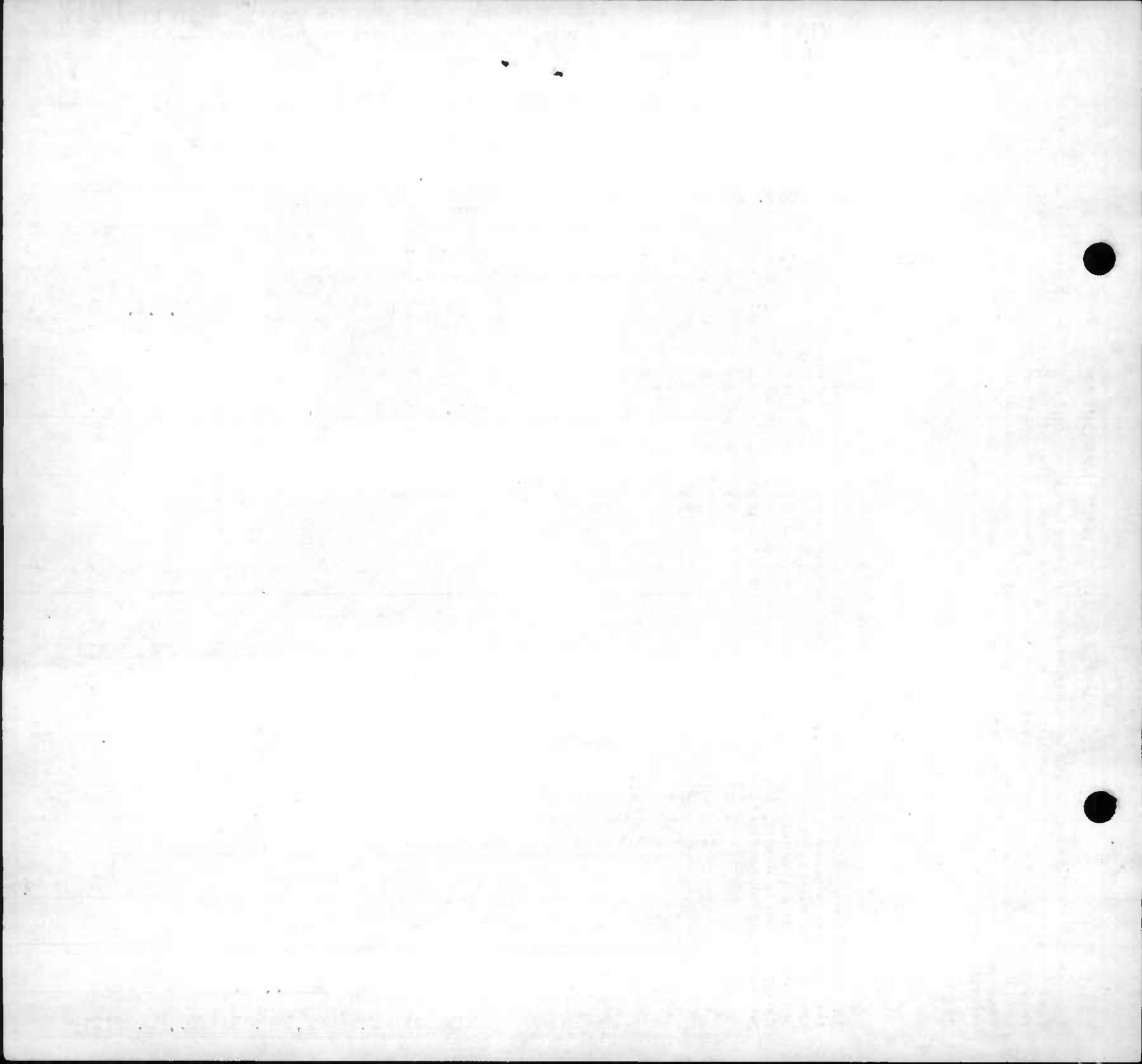
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0646	
BIRTH NO. 65 0646				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Furlong, Peter Joseph</i>				1/18/1965 1:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp.</i>				A. STATE <i>Md</i> B. COUNTY <i>12-02</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
				D. STREET ADDRESS (If rural, give location) <i>Maryland Apts.</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>S</i>	8. DATE OF BIRTH <i>8/31/80</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>ENGINEERING</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Patrick Furlong</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Murphy</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>220-44-6424</i>		17. INFORMANT ADDRESS <i>MISS ELLA G. NANNA C. FURLONG (SAME)</i>
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>ASCVD</i>				(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO	
				(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/26</i> 19 <i>65</i> to <i>1/18</i> 19 <i>65</i> , that (I) <i>(we)</i> first saw the deceased alive on <i>1/18</i> 19 <i>65</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>C. B. Wallace</i> M.D.				23B. DATE SIGNED <i>1/18/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. C. B. WALLACE</i>				23D. ADDRESS <i>DRUGGAS STONE M.D. 10 Union Memorial Hosp</i>	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>Burial 1/21/1965</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

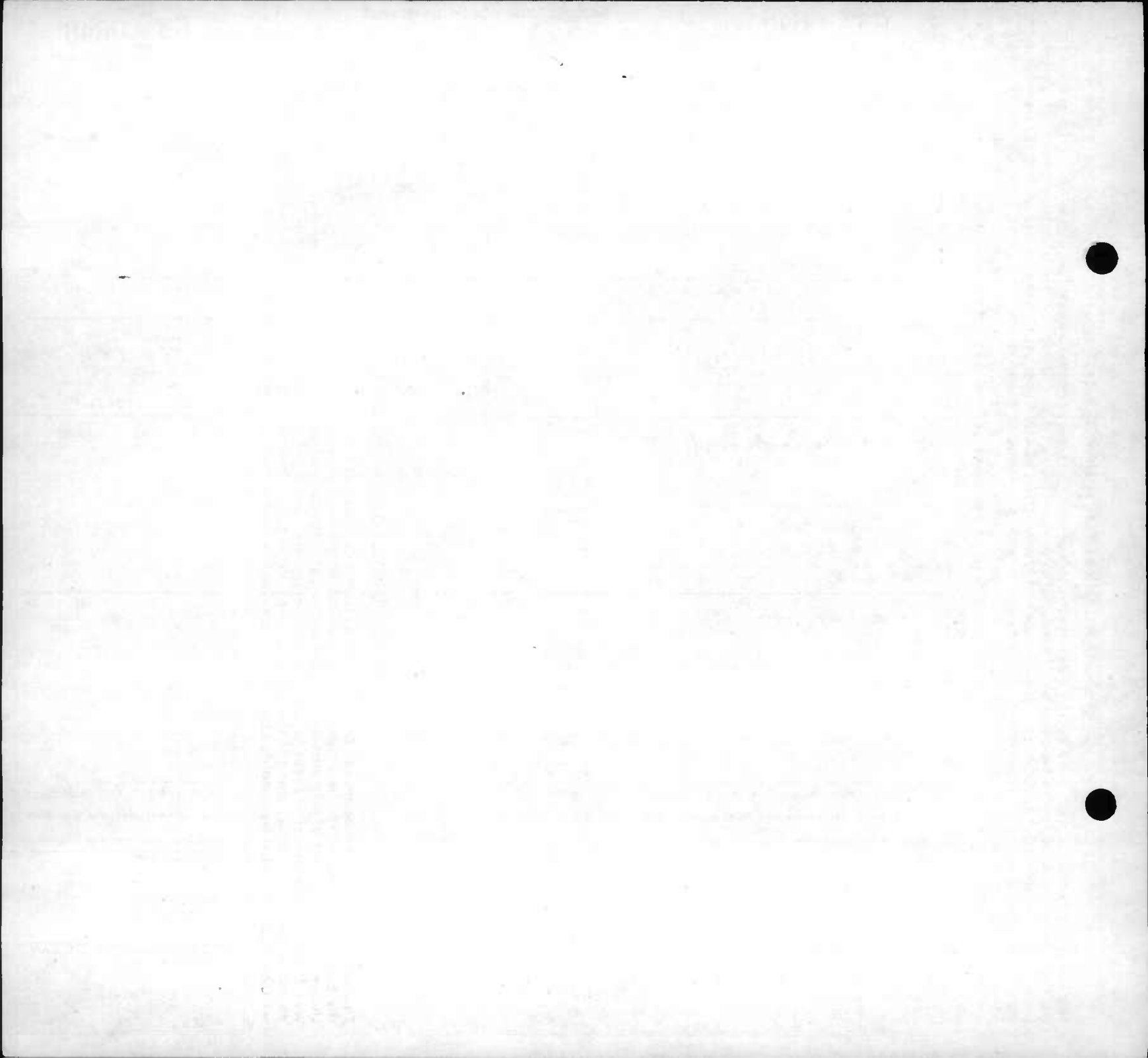
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0647		CERTIFICATE OF DEATH		65 0647	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA ROBEL		2. DATE AND HOUR OF DEATH 1/17/65 11:15 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PARK HILL CONV. HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 7702 WILSON AVENUE			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5/7/1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM ROBEL		14. MOTHER'S MAIDEN NAME MARGARET	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. GEORGE WILT, 8714 Maravoss Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 445X-260X CAUSE OF DEATH (A) Hypertensive Art. Fel. Card. Vascularis. (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH years			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus, unid.		20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/27 1963 to 1/17 1965 , that (I) (we) last saw the deceased alive on 1/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis V. Blum, M.D.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/17/65	
23C. PHYSICIAN'S NAME (Type) Louis V. Blum		23D. ADDRESS 3502 W. Rogers Ave. Baltimore 20215 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/20/65		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC. BALTO., MD. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

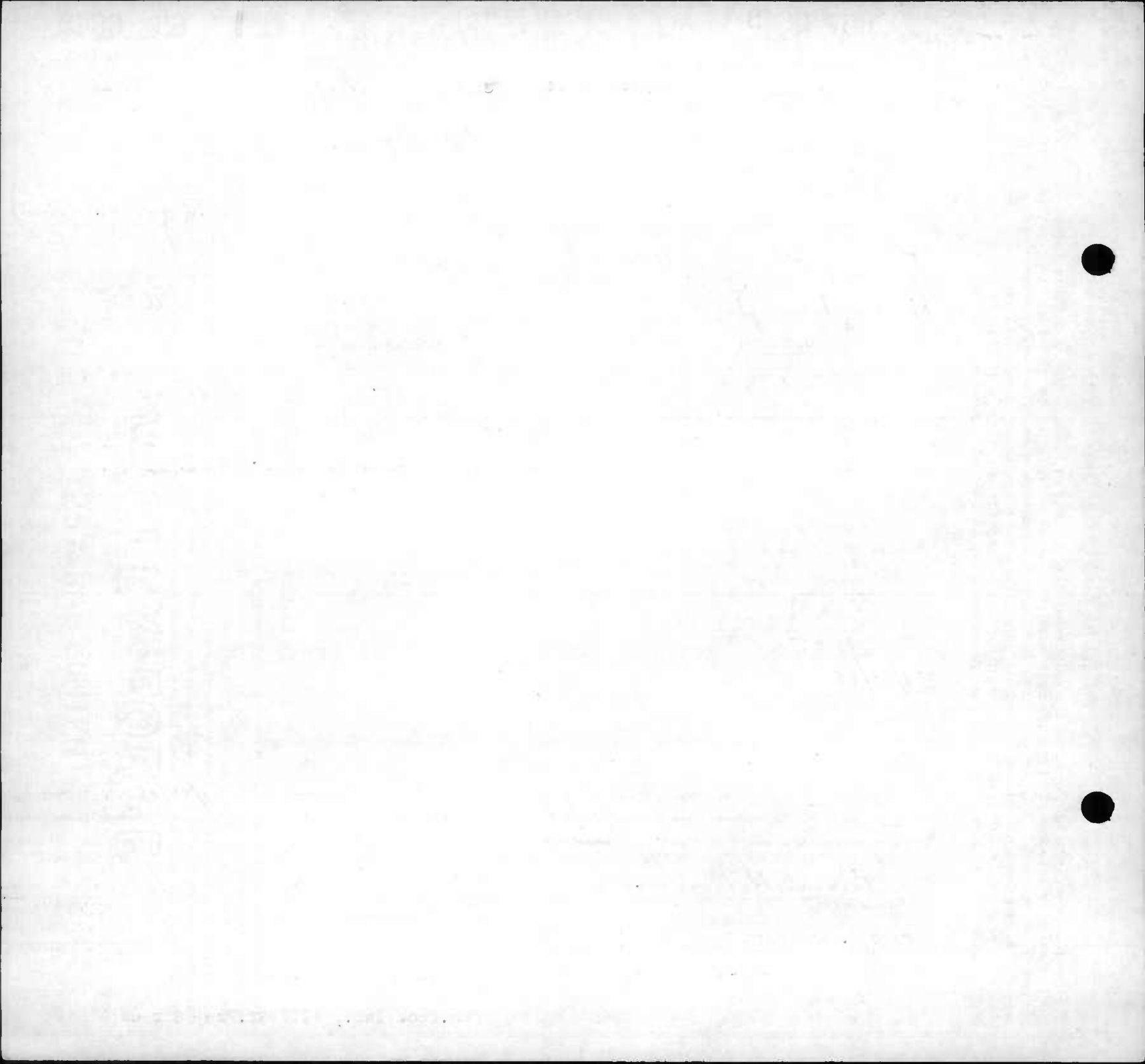
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0648	
<div> <div>BIRTH NO. 65 0648</div> <div>CERTIFICATE OF DEATH</div> </div>					
<div> <div>M.E. CASE NO. 65-0180</div> <div>1. NAME OF DECEASED (Type or Print) Donna Marie Anderson</div> <div>2. DATE AND HOUR OF DEATH 1-19-65 12¹⁰-AM.</div> </div>					
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> </div> </div>			<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</div> <div> <div>A. STATE Md.</div> <div>B. COUNTY 7-06</div> </div> </div>		
<div> <div>5. SEX Female</div> <div>6. RACE White</div> </div>			<div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) -</div> <div>8. DATE OF BIRTH 1-16-65</div> </div>		
<div> <div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -</div> <div>10B. KIND OF BUSINESS OR INDUSTRY -</div> </div>			<div> <div>9. AGE (In years last birthday) -</div> <div>11. BIRTHPLACE (State or foreign country) Maryland</div> </div>		
<div> <div>13. FATHER'S NAME Robert Melvin Anderson</div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -</div> </div>			<div> <div>12. CITIZEN OF - WHAT COUNTRY? U. S. A</div> <div>14. MOTHER'S MAIDEN NAME Sandra Lynn Ewing</div> </div>		
<div> <div>16. SOCIAL SECURITY NO. -</div> <div>17. INFORMANT Mr. Robert M. Anderson</div> </div>			<div> <div>ADDRESS 1616 E. 32nd St.</div> </div>		
<div> <div>18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</div> <div>CAUSE OF DEATH (A) Prematurity</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>					
<div> <div>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> <div>19A. DATE OF OPERATION 0</div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>20A. AUTOPSY? (Yes or No) No</div> <div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> </div>					
<div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> </div>					
<div> <div>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</div> <div>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> <div>21F. HOW DID INJURY OCCUR?</div> </div>					
<div> <div>22. I certify that (I) (this hospital) attended the deceased from 1-16-1965 to 1-19-1965, that (I) (we) last saw the deceased alive on 1-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> </div>					
<div> <div>23A. SIGNATURE Steven J. Alamedis</div> <div>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></div> </div>				<div> <div>23B. DATE SIGNED 1-19-65</div> </div>	
<div> <div>23C. PHYSICIAN'S NAME (Type) Robert E. Farley, M.D.</div> <div>23D. ADDRESS</div> </div>					
<div> <div>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</div> <div>24B. DATE 1/20/65</div> </div>		<div> <div>24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery</div> <div>24D. LOCATION (City, town, or county) Baltimore, Md.</div> </div>			
<div> <div>25A. DATE REC'D BY HEALTH DEPT. JAN 19 1965</div> <div>25B. NAME OF REGISTRAR Robert E. Farley, M.D.</div> </div>		<div> <div>25C. FUNERAL DIRECTOR Leonard J. Ruck</div> <div>ADDRESS 5305 Highland Ave</div> </div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0649	
BIRTH NO. 65 0649				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian XXXXXXXXXXXX</i>		2. DATE AND HOUR OF DEATH <i>1/18/65 6:45 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>402</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>102 N. Paen St. (Century Nursing Home)</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8/16/84</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Month Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nursing home pt.</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Century Nursing Home</i>	
18. <i>5-870 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) <i>Acute & chronic pancreatitis.</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>1/13/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/12/65</i> 19__ to <i>1/18/65</i> 19__, that (I) (we) last saw the deceased alive on <i>1/18/65</i> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Bruce H. MacPherson</i> M.D.				23B. DATE SIGNED <i>1/18/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bruce H. MacPherson</i>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-21-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook, Inc., 1217 St. Paul Street, 21202</i>	



B-2601

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 0650

BIRTH NO.

65 0650

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICK ALBERT BAKER

2. DATE AND HOUR OF DEATH

JANUARY 17, 1965 2:52 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)UNION MEMORIAL Hospital
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3524 BUENA VISTA AVENUE

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7/29/08

9. AGE (In years
last birthday)

56

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ham processing

10B. KIND OF BUSINESS OR INDUSTRY

Goetze Meat Co

11. BIRTHPLACE (State or foreign country)

MARYLAND (Cumberland)

12. CITIZEN OF
WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

Joseph BAKER

14. MOTHER'S MAIDEN NAME

MARGARET SMITH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL
SECURITY NO.

219-01-0946H

17. INFORMANT

ADDRESS

DOROTHY L. BAKER 3524 BUENA VISTA AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.(A) Carcinoma of the left main stem bronchus
DUE TO
metastasis to both lung, regional & distant
lymph nodes and right diaphragm.
(B) Bilateral pneumonia
DUE TO
+ bronchopneumonia
(C) Cardiomegaly & left ventricular dilatation
fibrous pericardial adhesions.
Generalized arteriosclerosis.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

3-6-65

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
Lymph Node Biopsy -

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 22 1964 to January 17 1965.
that (I) (we) last saw the deceased alive on January 16 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David McNeill Mac Millan

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/17/65

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-20-65

24C. NAME OF CEMETERY or CREMATORY

St. Mary's Hampden

24D. LOCATION

(City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1965

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

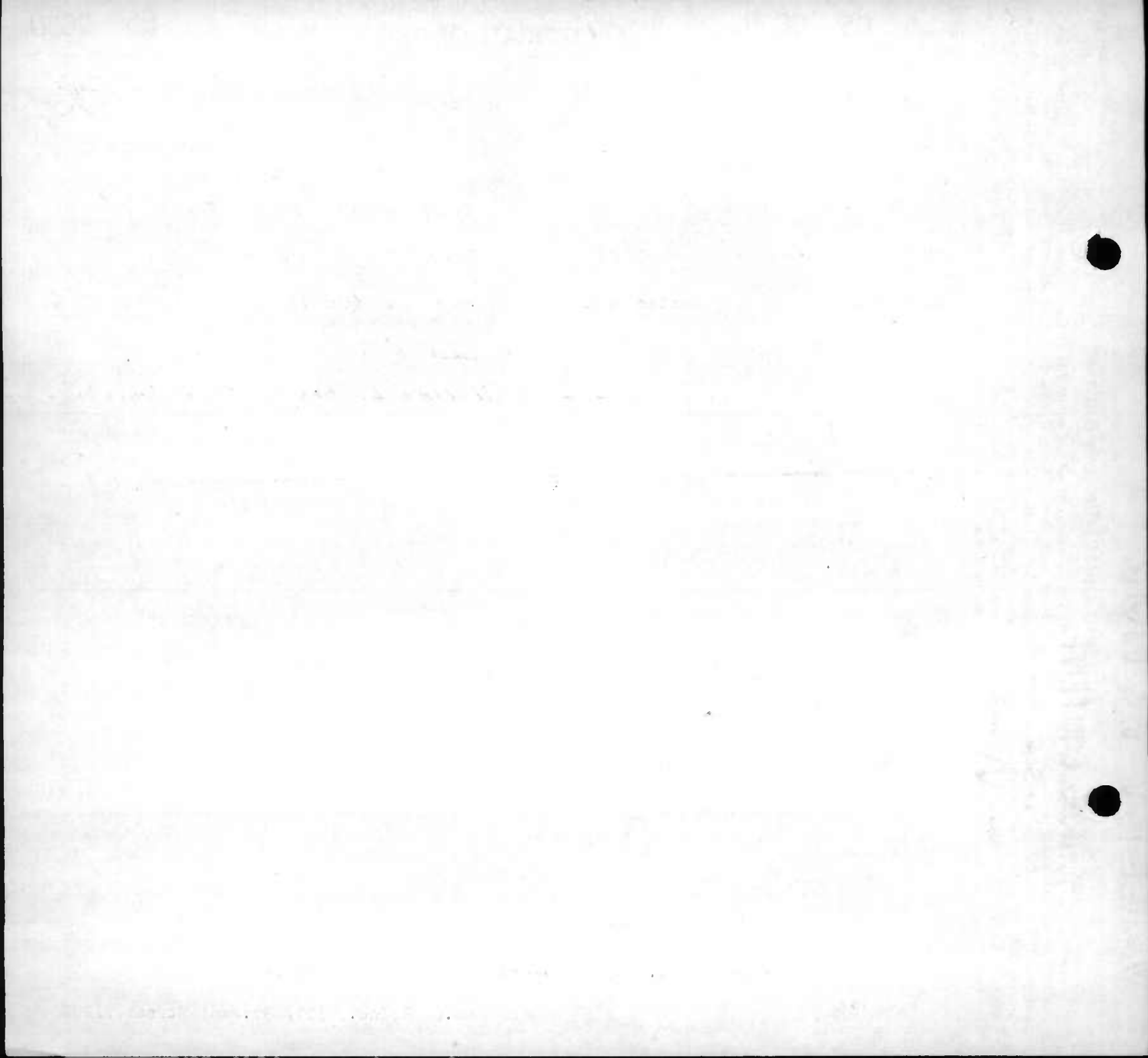
25C. FUNERAL DIRECTOR

Wm. Cook, Inc., 1217 St. Paul Street, 21202

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



H. 635

65 0651

BALTIMORE CITY HEALTH DEPARTMENT

65 0651

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59343

1. NAME OF DECEASED
(Type or Print)

WALTER J. HARDING

2. DATE AND HOUR PRONOUNCED DEAD

1-17-65

10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2521 Maryland Avenue - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2521 Maryland Avenue 21218

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

November 3, 1896

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter J. Harding

14. MOTHER'S MAIDEN NAME

Theresa Lammers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Rhea Kane, 2521 Maryland Avenue, 212018

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Papillary carcinoma of left renal pelvis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RICKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-21-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul Street, 21202

ALBANY POLICE

PAGE CONTINUED

NOV 1 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death may show: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

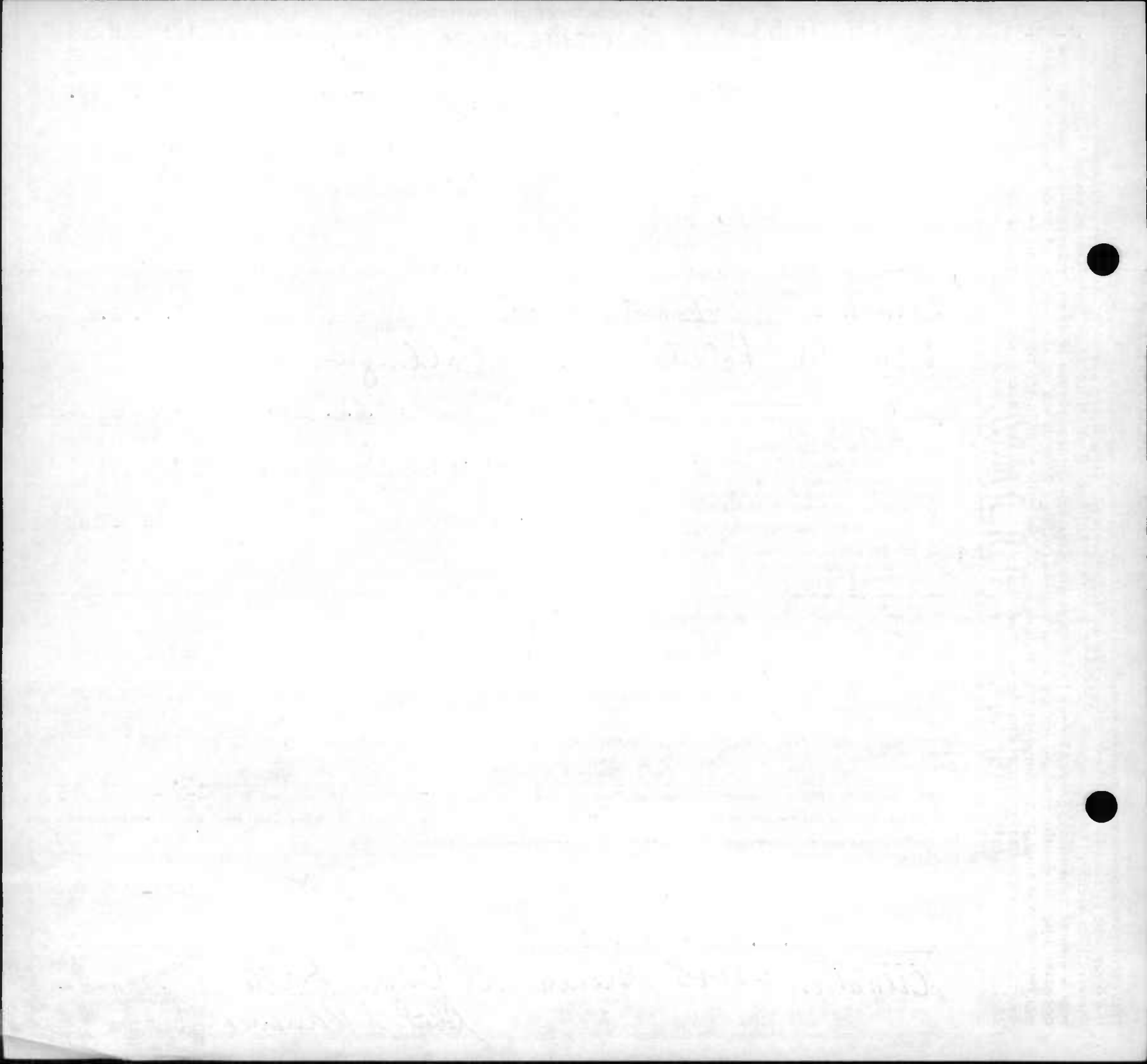
Baltimore City Health Department				Registered No.	
H#400 65 0652		BIRTH NO. 65 0652		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EVA MAY HOLLEY		1-19-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		Kent	
33 JOHNS HOPKINS HOSPITAL		MARYLAND.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		MILLINGTON		64-00	
D. STREET ADDRESS (If rural, give location)		ROUTE 1, BOX 254			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	NEGRO	MARRIED	8-3-99	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABOR		FACTORY		KENT CO.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
SAM SCOTT		ANNA MOLLOCK		U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		YES		Wm. H. Holley Millington, Md	
18. 141.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Hypo tension		?	
		(B) SEPSIS, PNEUMONIA		?	
		(C) METASTATIC CANCER (PRIMARY OF TONGUE)		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/12 1965 to 1:45 AM 1/19 1965, that (I) (my) last saw the deceased alive on 1/18/19 65 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael Lesch				1/19/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. MICHAEL LESCH.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/23/65		Chester VILLE CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 19 1965		Robert E. Fisher, M.D.		Kenneth Waller	
				ADDRESS	
				Chester Town, Md	



FUNERAL DIRECTOR: IMPORTANT

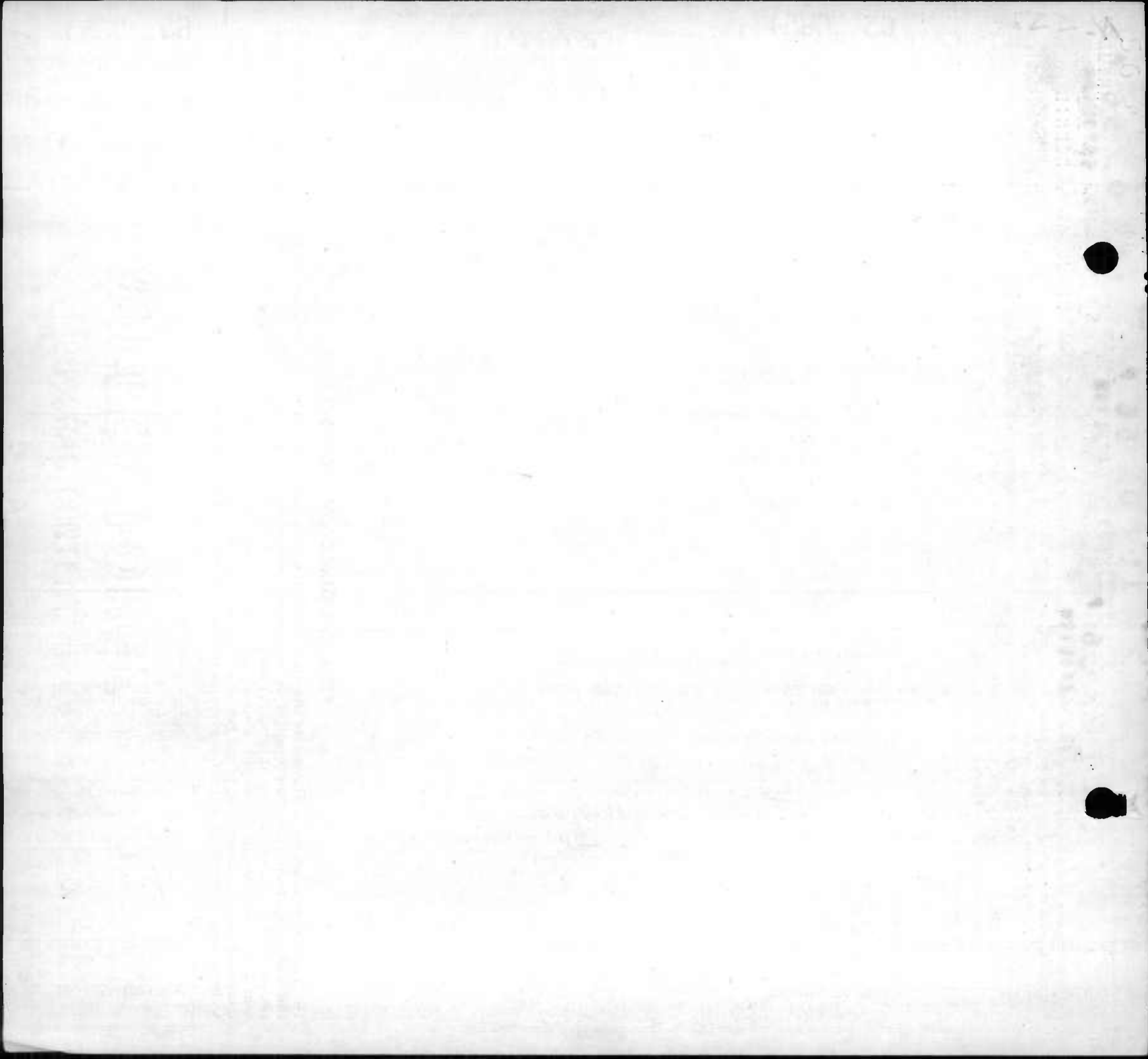
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0653</u>	
BIRTH NO. <u>65 0653</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Harriet Barden</u>			
2. DATE AND HOUR OF DEATH <u>1-17-65</u> <u>8:30 P.</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel County</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Rural Severna Park 52-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>302 Maple Lane</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-7-17</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Element. School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Wm. M. Roberts</u>			
14. MOTHER'S MAIDEN NAME <u>Collingwood</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>289076040</u>		17. INFORMANT <u>RECORDS: B.C.H. 4940 Eastern Avenue #21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteritis ? Collagen Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Same</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> 19 <u>64</u> to <u>1-17-</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-17</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. C. Robert Cooke</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-17-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. C. Robert Cooke</u>		23D. ADDRESS <u>4940 Eastern Avenue #21224</u>			
24A. BURIAL OR CREMATION <u>Cremation</u>		24B. DATE <u>1-21-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crem.</u>	
24D. LOCATION <u>Baltimore</u>		(City, town, or county) (State) <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert J. Bananco - Severna Pk. Md.</u>	



114 03 56 P
NIMMONS, CAROLYNN
114 03 56 P
FURNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the local medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0654				
BIRTH NO. 65 0654									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Carolyn Nimmmons					2. DATE AND HOUR OF DEATH 1/17/65 9:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33					A. STATE MARYLAND B. COUNTY ALLEGANY				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) CUMBERLAND 51-02				
					D. STREET ADDRESS (If rural, give location) 211 WALLACE ST				
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-15-40	9. AGE (In years last birthday) 25	If Under 1 Yr. Months Days Hours Min.		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LAWRENCE GATES					14. MOTHER'S MAIDEN NAME SYLVIA STEPHENS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ERNEST J. NIMMONS, CUMBERLAND, MD,				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Circulatory Failure DUE TO CNS Disease of undetermined Cause (B) _____ DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 weeks				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12/23 1964 to 1/17 1965, that (I) (we) last saw the deceased alive on 1/17/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE D. Edwards Smith					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/17/65	
23C. PHYSICIAN'S NAME (Type) D. Edwards Smith					23D. ADDRESS M.D. Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE JAN. 21, 1965		24C. NAME OF CEMETERY or CREMATORY ROSE HILL CEMETERY		24D. LOCATION (City, town, or county) (State) CUMBERLAND, MD.		
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965			25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR BYRON KIGHT			ADDRESS CUMBERLAND, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

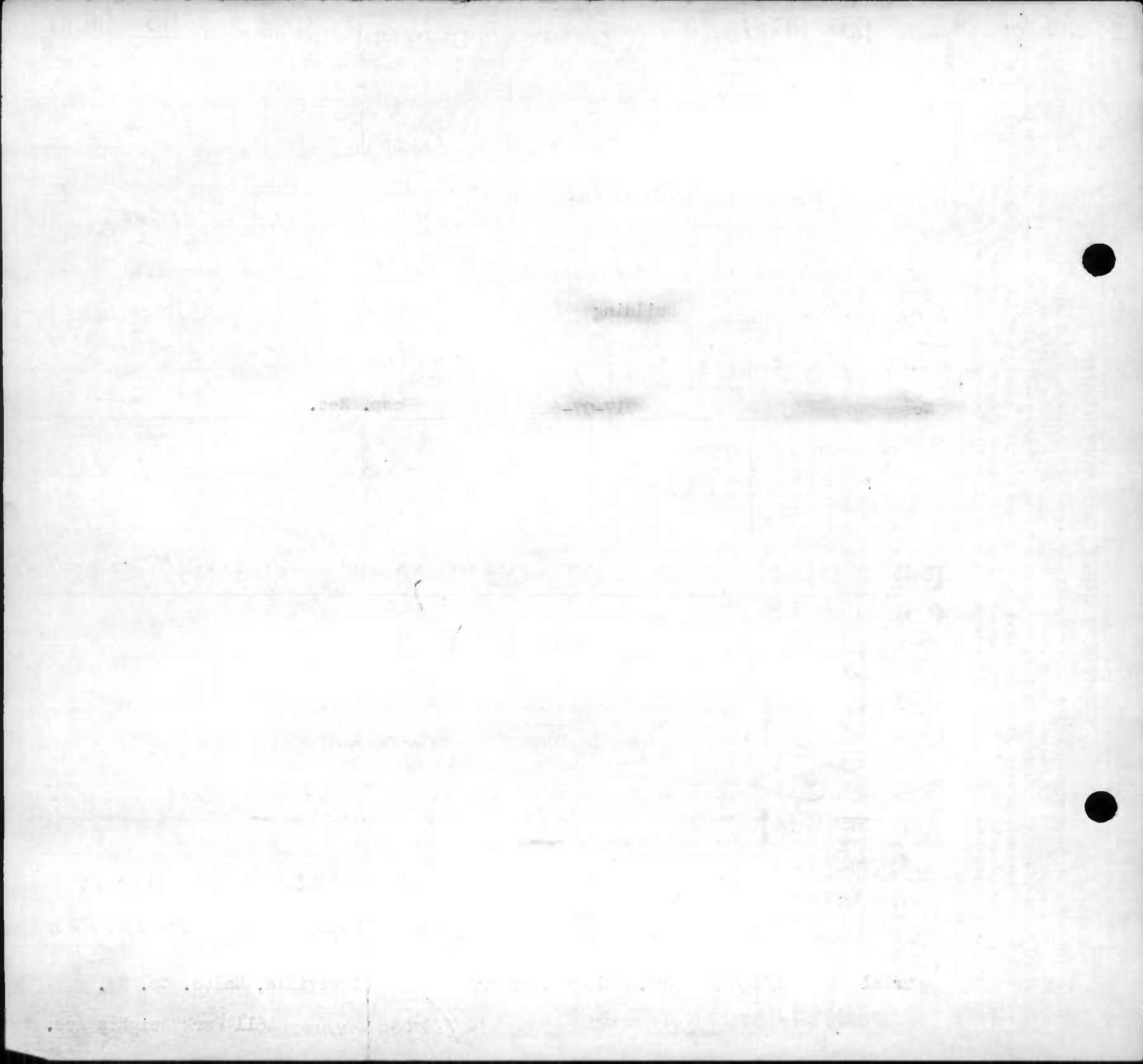
BIRTH NO. 65 0655		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0655	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		BABY BOOY BASKETTE		2. DATE AND HOUR OF DEATH 1-18-65 5:20PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED HOSPITAL OR INSTITUTION The Johns Hopkins Hospital 9-20-65		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 21 PATAPSCO AVENUE 53-00			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-18-64	9. AGE (In years last birthday) 1 1	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Grace J. CATHERINE BASKETTE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 086X I Metabolic acidosis Rubella Syndrome		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 hours 31 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/17 1965 to 1/18 1965, that (I) (we) last saw the deceased alive on 1/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louie Linarelli M.D.				23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) LOUIE LINARELLI		23D. ADDRESS Johns Hopkins			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 1-19-65		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS HOSPITAL	
24D. LOCATION (City, town, or county) BALTIMORE 5, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965			
25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR ADDRESS 0 6 5 5			

Corrected by Birch Cent. 64-35352
9-20-65 MH.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

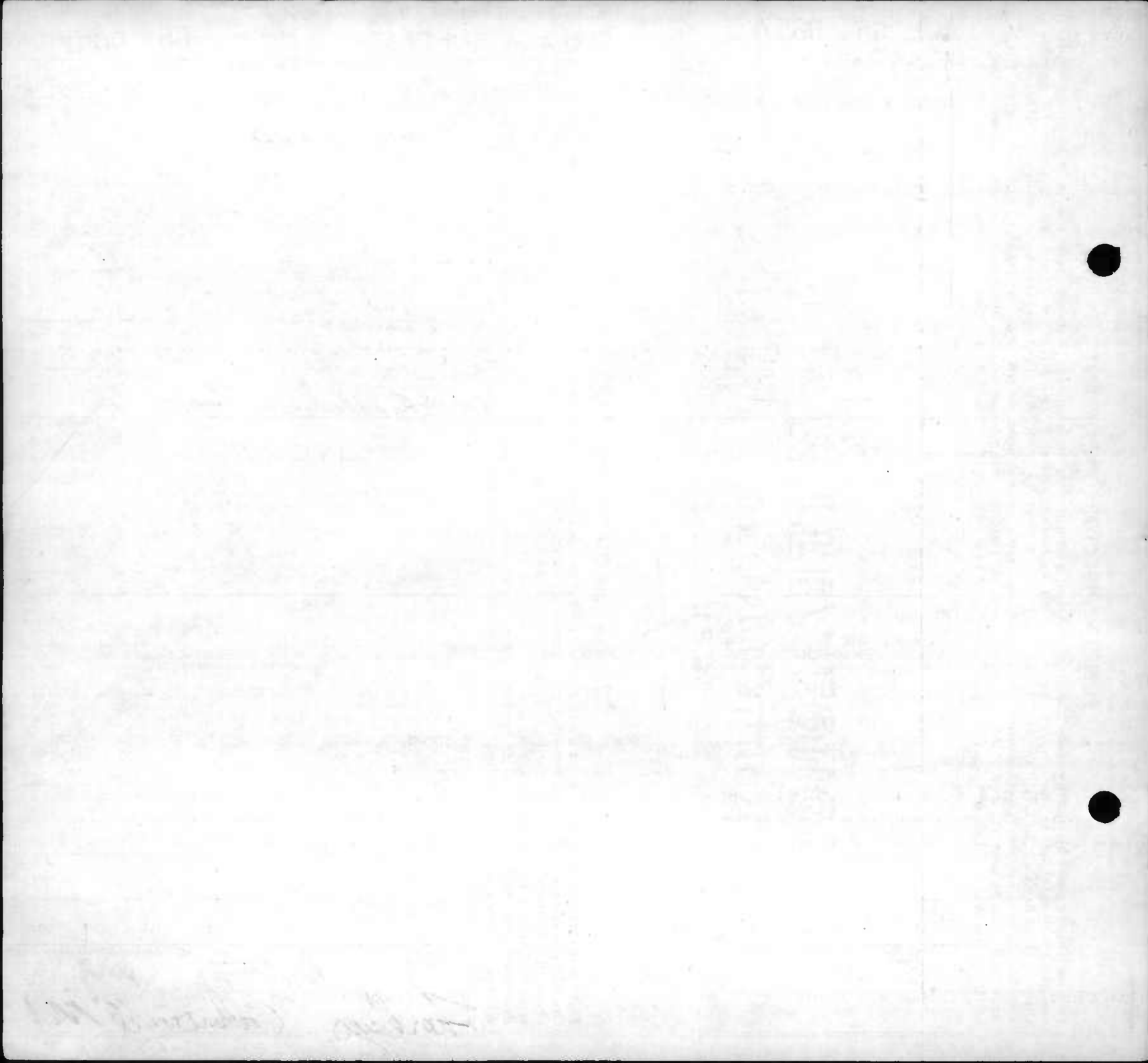
BIRTH NO. 65 0656		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0656	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Arthur J. Eckenrode</u>		2. DATE AND HOUR OF DEATH <u>1-18-65</u> <u>8⁰⁵</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>27-17</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3004 Woodland Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>9/27/97</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John Eckenrode</u>		14. MOTHER'S MAIDEN NAME <u>ANASTIA NOEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN (U.S.A.)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-6182</u>		17. INFORMANT <u>Hosp. Rec.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>METASTATIC CANCER</u>		(B) DUE TO			
		(C) <u>CARCINOMA of Sigmoid</u>		<u>4 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CHF</u>					
19A. DATE OF OPERATION <u>09-21-64</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA of Sigmoid</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>12/15</u> 19 <u>64</u> to <u>1/18</u> 19 <u>65</u> , that (I) <u>did</u> saw the deceased alive on <u>1/18</u> 19 <u>65</u> and that in (my) <u>apin</u> death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>William N. Bennett</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-18-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>William N. BENNETT</u>		23D. ADDRESS <u>UNION MEMORIAL Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>B. Vernon Lemon</u>	
				ADDRESS <u>4611 Park Heights Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

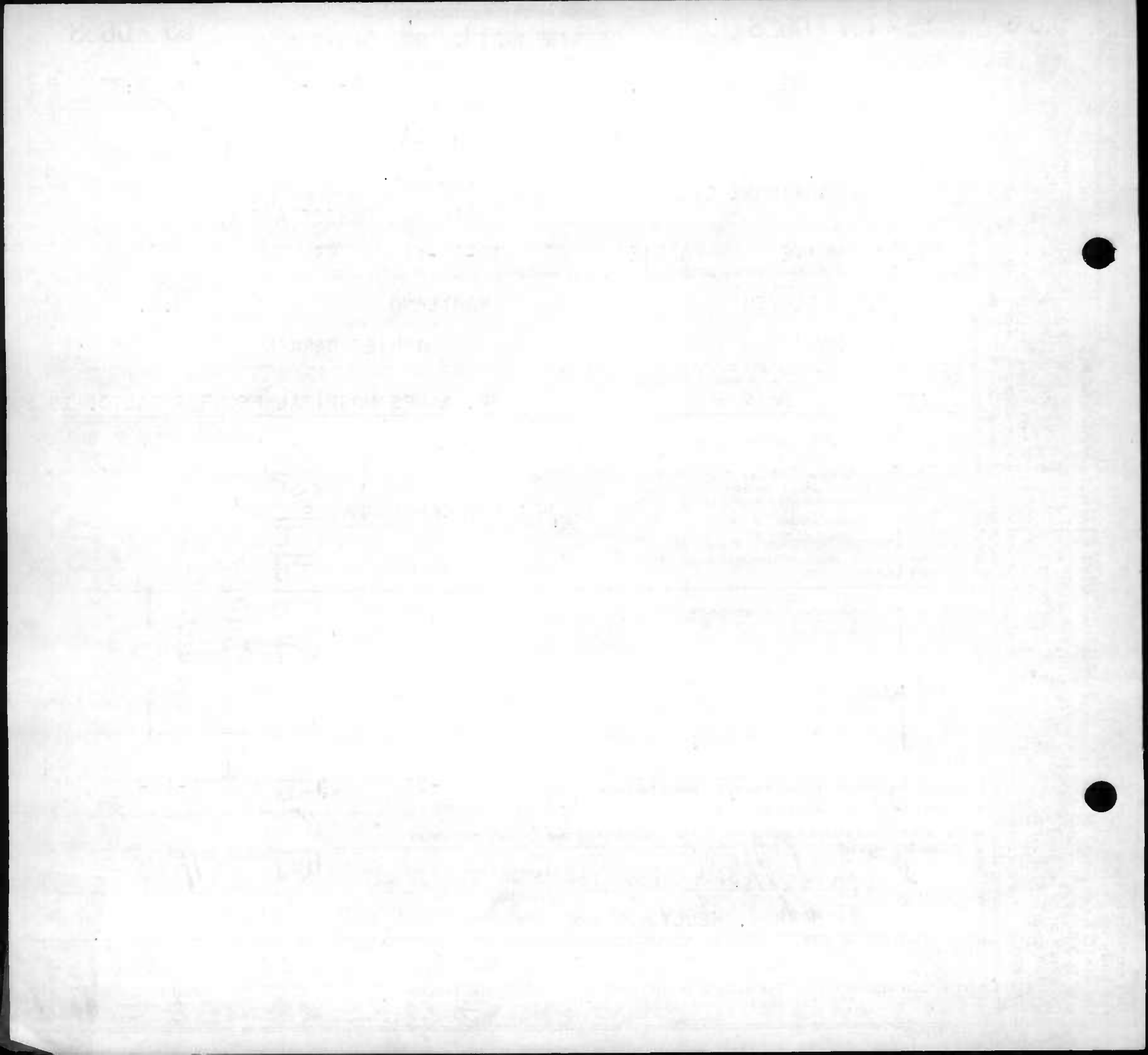
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0657</u>	
BIRTH NO. <u>65 0657</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>TIMOTHY JOSEPH RANDLE</u>		2. DATE AND HOUR OF DEATH <u>1-16-65 1:10³⁰ A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>25-31</u>			
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>---</u>				8. DATE OF BIRTH <u>1-14-65</u>		9. AGE (In years last birthday) <u>---</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>---</u>				13. FATHER'S NAME <u>ALBERT LOUIS RANDLE</u>			
14. MOTHER'S MAIDEN NAME <u>ANN GENEVIEVE DEMENT</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>---</u>			
16. SOCIAL SECURITY NO. <u>---</u>				17. INFORMANT ADDRESS <u>Albert Randle - 4360 Parkton St.</u>			
18. <u>762.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MASSIVE MYOCARDIAL INFARCTION</u>				CAUSE OF DEATH (A) <u>Massive Myocardial Infarction of both lungs</u> (B) <u>Prematurity</u> (C) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>---</u>				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>---</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>---</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>---</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>---</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>---</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>---</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>January 15</u> 19 <u>65</u> to <u>Jan. 16</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Florino Francisco</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/16/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Florino A. Francisco</u> M.D.				23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-18-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Ind.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>		25C. FUNERAL DIRECTOR <u>Farley</u>		ADDRESS <u>Catonville, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

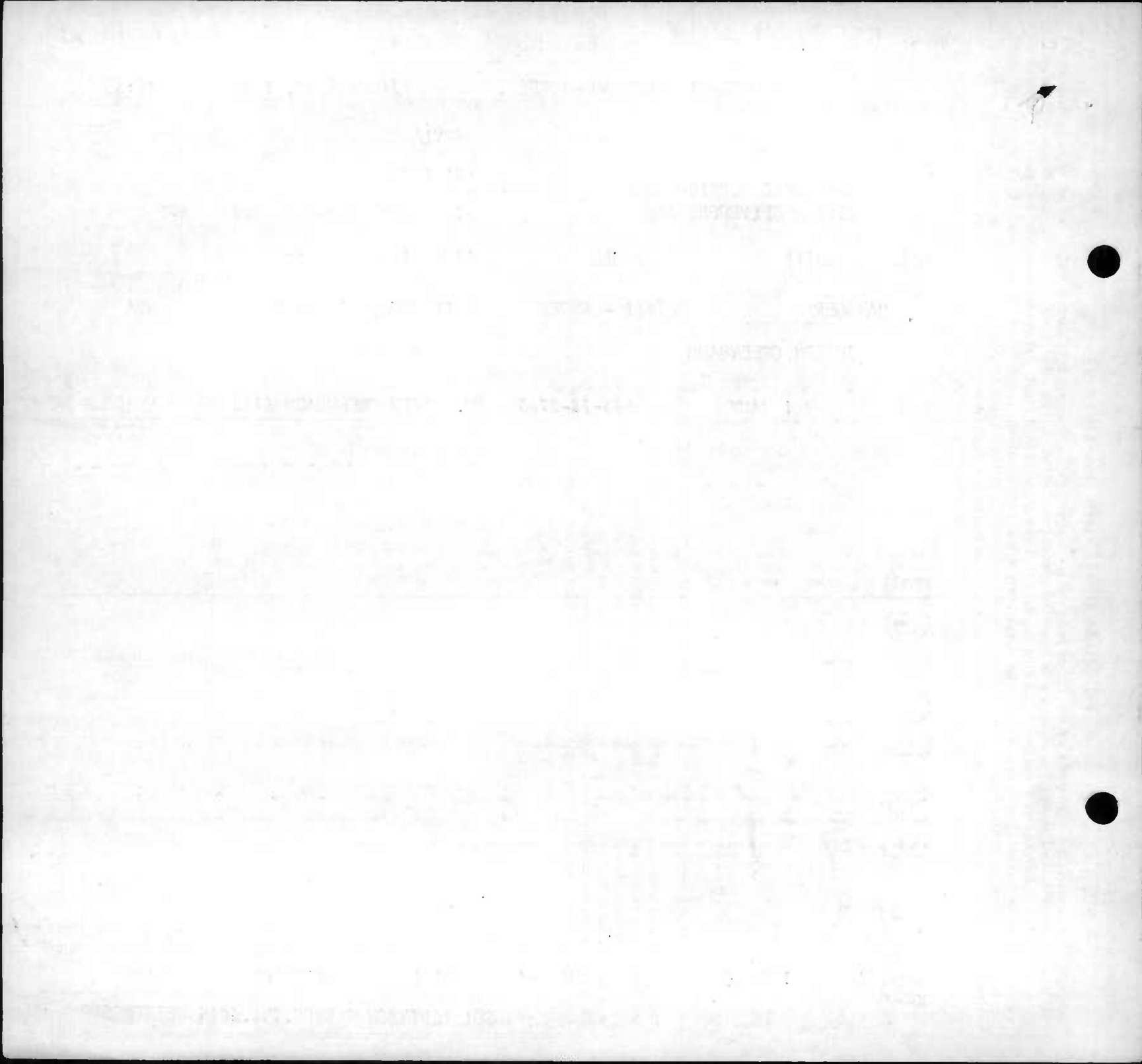
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 0658					CERTIFICATE OF DEATH X Registered No. 65 0658					
1. NAME OF DECEASED (Type or Print) ROWE, JOHN B.					2. DATE AND HOUR OF DEATH 1-17-65 4:35 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE 29, MD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 410 OAK FOREST AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-23-11	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN ROWE					14. MOTHER'S MAIDEN NAME HARRIET BARKER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS BALTO. 29, MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO (B) PRIMARY CARCINOMA OF LUNG DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 9-21-64 to 1-17-1965, that (we) last saw the deceased alive on 1-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.										
23A. SIGNATURE Richard J. Kelly M.D.					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/17/65			
23C. PHYSICIAN'S NAME (Type) RICHARD J. KELLY, MD					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965			25B. NAME OF REGISTRAR Robert E. Farley M.D.			25C. FUNERAL DIRECTOR Foley Funeral Home - Catonsville, Md.			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0659					CERTIFICATE OF DEATH			Registered No. 65 0659	
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) MICHAEL GREENBAUM (GREEN)					JANUARY 19, 1965 12:35 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME 2525 W BELVEDERE AVE					A. STATE MARYLAND B. COUNTY 27-15				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 6156 GREEN MEADOWS PKWY APT C				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11/20/1894	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER			10B. KIND OF BUSINESS OR INDUSTRY RETAIL - SHOES		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH GREENBAUM					14. MOTHER'S MAIDEN NAME MARY WEINBERG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1 NAVY			16. SOCIAL SECURITY NO. 563-18-2763		17. INFORMANT MR. DAVID GREENBAUM			ADDRESS APT C 6156 GREEN MEADOWS PKWY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) DUE TO Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. DUE TO Carcinoma of Colon OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 year + 1 year +				
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 20 1964 to Jan 19 1965, that (I) (we) last saw the deceased alive on Jan 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. A. Silver					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) A. A. SILVER					23D. ADDRESS M.D. TEMPLE GARDENS APT. BALTO.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH - (AITZCHAIM)		24D. LOCATION BALTIMORE		(City, town, or county) (State) MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965			25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR & ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN, MD				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 0660

BIRTH NO. 65 0660

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(TESSIE)

Celeste Naviasky

2. DATE AND HOUR OF DEATH

January 18, 1965 5:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

27-020

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3902 Fordleigh Rd.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9/4/02

9. AGE (In years last birthday)

62

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

Baltimore MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSEPH DAVID

14. MOTHER'S MAIDEN NAME

HANNAH GOLDMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-36-2333

17. INFORMANT

ADDRESS

MISS HELEN S. NAVIASKY 3902 FORDLEIGH RD

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Myocardial Infarction

DUE TO

2 day

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

?

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(H)~~ (this hospital) attended the deceased from January 17 19 65 to January 18 19 65, that (I) ~~(lost)~~ saw the deceased alive on January 18 19 65 and that in (my) ~~(lost)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(lost)~~ (did) (did not) view the body after death.

23A. SIGNATURE

Harry M. Charkatz

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/18/65

23C. PHYSICIAN'S NAME (Type)

Harry M. Charkatz

M.D.

23D. ADDRESS

Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/20/65

24C. NAME OF CEMETERY or CREMATORY

HEBREW FRIENDSHIP

24D. LOCATION

(City, town, or county)

BALTIMORE

MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

ADDRESS

1. The first part of the report is a general statement of the work done during the year.

2. The second part is a detailed account of the work done in each of the several departments.

3. The third part is a summary of the results of the work done during the year.

4. The fourth part is a list of the names of the persons who have been employed during the year.

5. The fifth part is a list of the names of the persons who have been employed during the year.

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

JOSEPH MASTER

2. DATE AND HOUR PRONOUNCED DEAD

1-18-65

1 8:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4810 Laurel Avenue - 21215

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

GROUNDS KEEPER

10B. KIND OF BUSINESS OR INDUSTRY

STATE COLLEGE

11. BIRTHPLACE (State or foreign country)

AUSTRIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MANUEL MASTER

14. MOTHER'S MAIDEN NAME

FANNIE HENDLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

041-01-8441

17. INFORMANT

MRS. FREDA MASTER

ADDRESS

4810 LAUREL AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Extensive coronary sclerosis with
multiple myocardial scars

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1/19/65

23C. NAME of CEMETERY or CREMATORY

PETVAH TEKVAH

23D. LOCATION

BALTIMORE

(City, town, or county)

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

SO. LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

ADDRESS

WALLEY POLICE

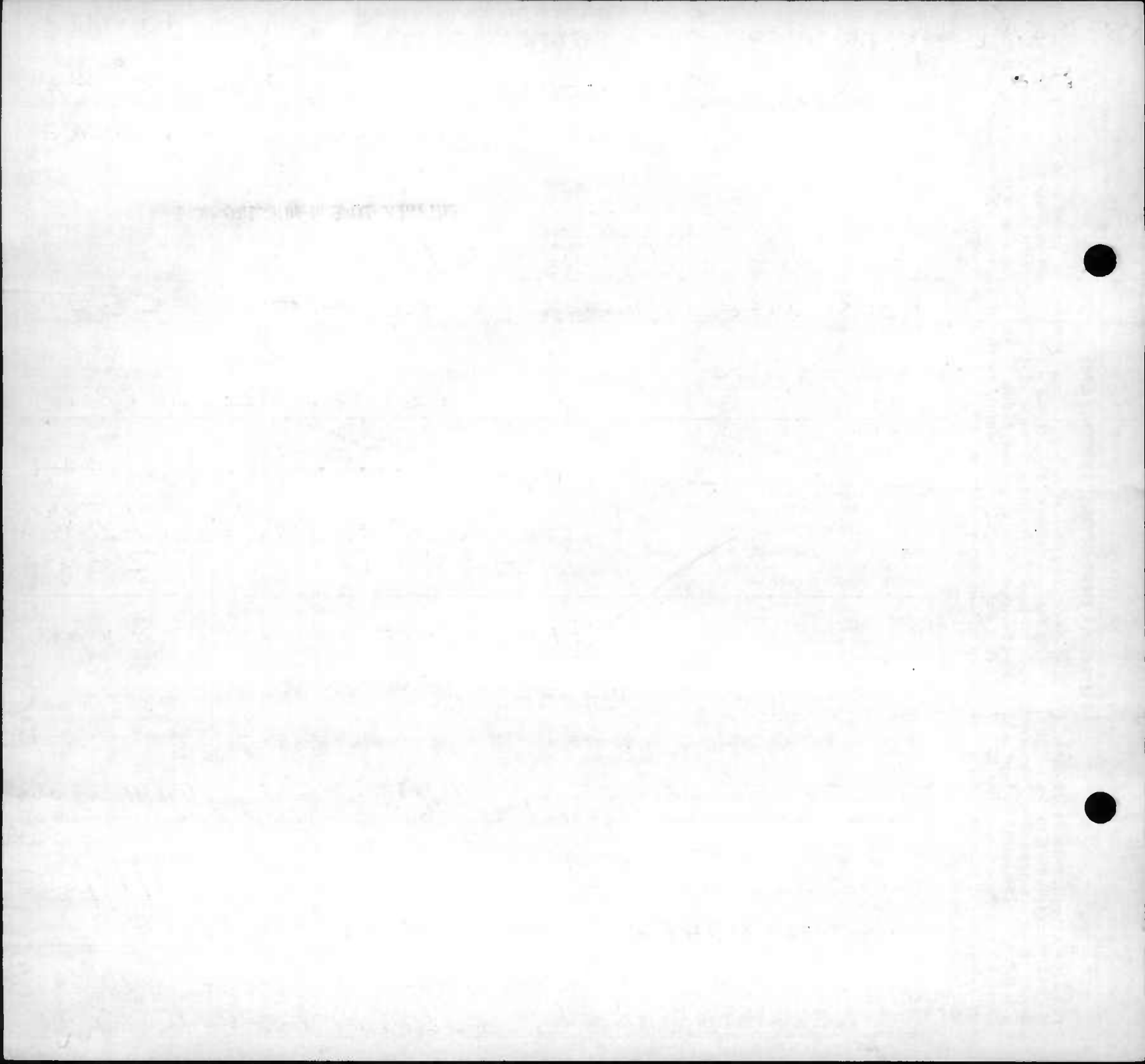
WALLEY POLICE

★ 100 X 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

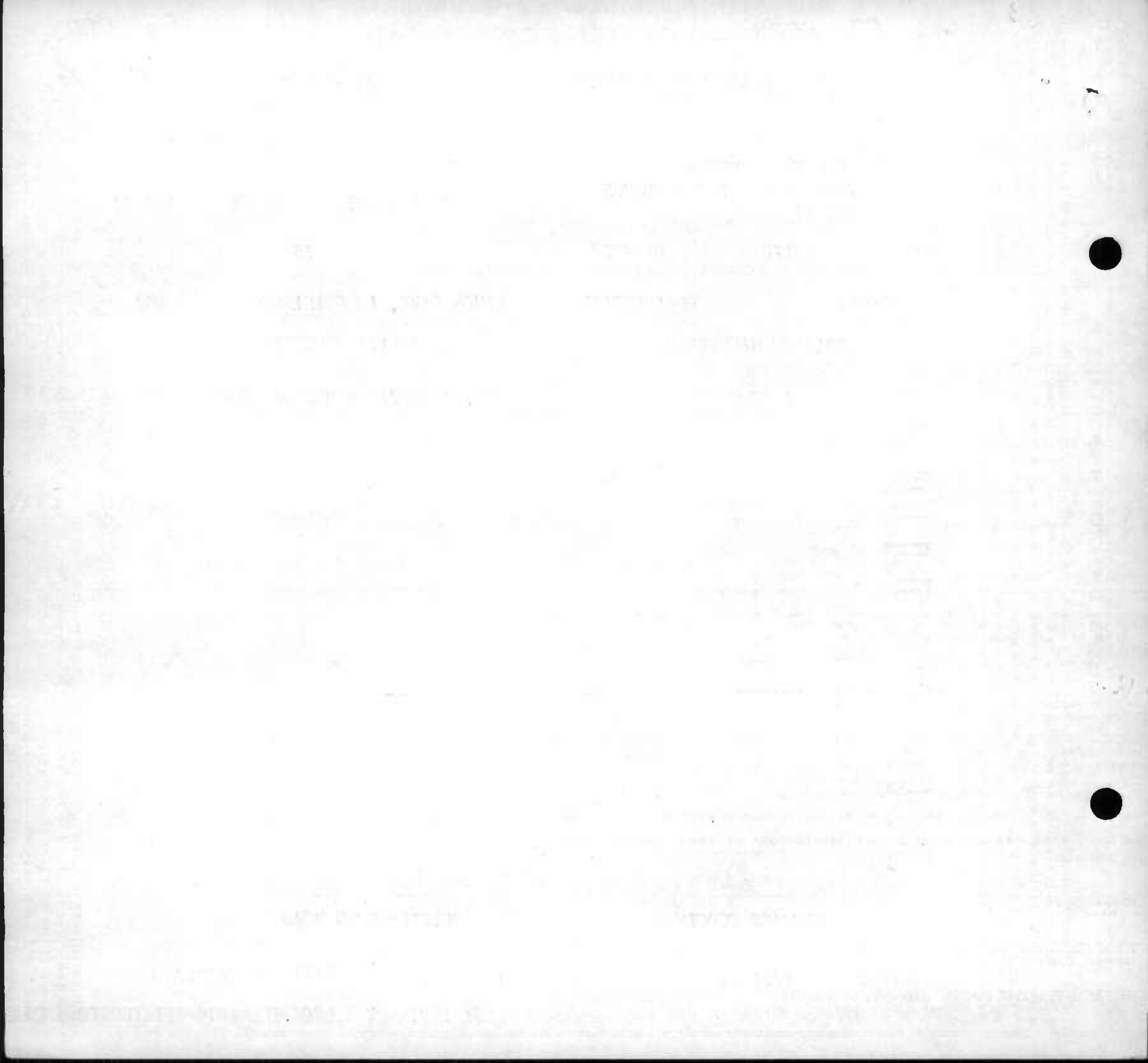
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0662	
BIRTH NO. 65 0662		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROSE STEINBACH		2. DATE AND HOUR OF DEATH 1/19/65 11:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		53-00	
				D. STREET ADDRESS (If rural, give location) DULANEY TOWSON NURSING HOME			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/25/1884	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Room				14. MOTHER'S MAIDEN NAME SARAH GERSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT HOSPITAL RECORDS.		ADDRESS	
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH A.P.E.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic Congestive Heart Failure & atrial fibrillation		15 yrs	
				(C) ASCVD		25 yrs	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		PNEUMONIA	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/18 19 65 to 1/19 19 65 . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/19 19 65 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel Muher				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) SAMUEL MUHER				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY Beth Hamedeorsh Hagadol		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Sol Lerman & Son Inc. 6010 Ristatow Rd.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

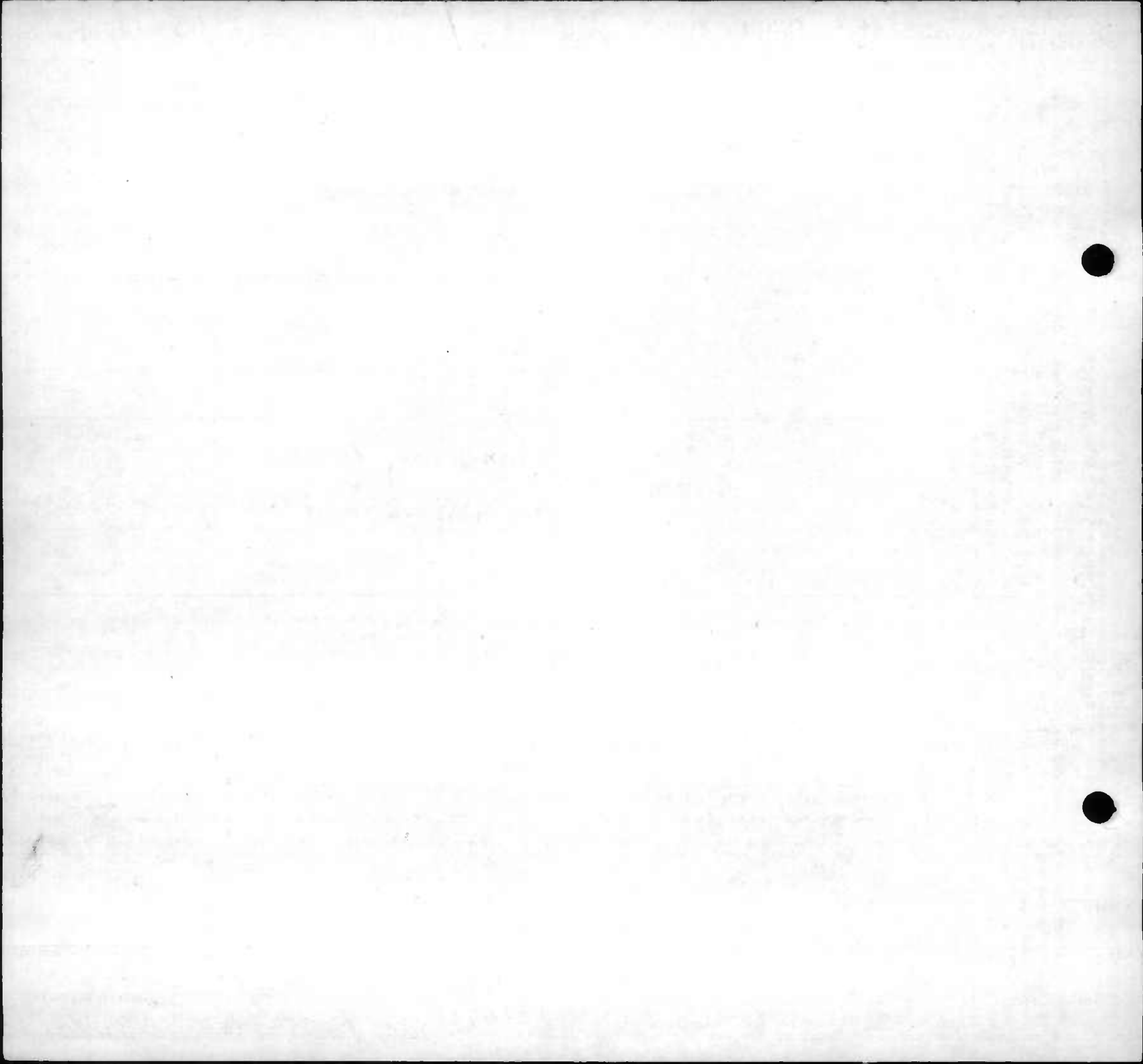
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0663	
BIRTH NO. 65 0663		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SAMUEL LAWRENCE HAMMERMAN		2. DATE AND HOUR OF DEATH 1/19/65 8:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SEMESTER APTMENTS 7000 PARK HEIGHTS AVENUE APT M1				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 7000 PARK HEIGHTS AVENUE APT M1							
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROKER		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) NEW YORK KINGS PARK, LONG ISLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SOLOMON HAMMERMAN				14. MOTHER'S MAIDEN NAME AMELIA ORNSTEIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1 ARMY		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. I HAROLD HAMMERMAN 3522 BARTON OAKS ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none				CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Arteriosclerotic H.D. (C) _____		INTERVAL BETWEEN ONSET AND DEATH minutes years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 58 to present 19 65 that (I) (we) last saw the deceased alive on Jan 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bernard Bergin				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) BERNARD BERGIN				23D. ADDRESS REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/21/65		24C. NAME of CEMETERY or CREMATORY CHIZUK AMINO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

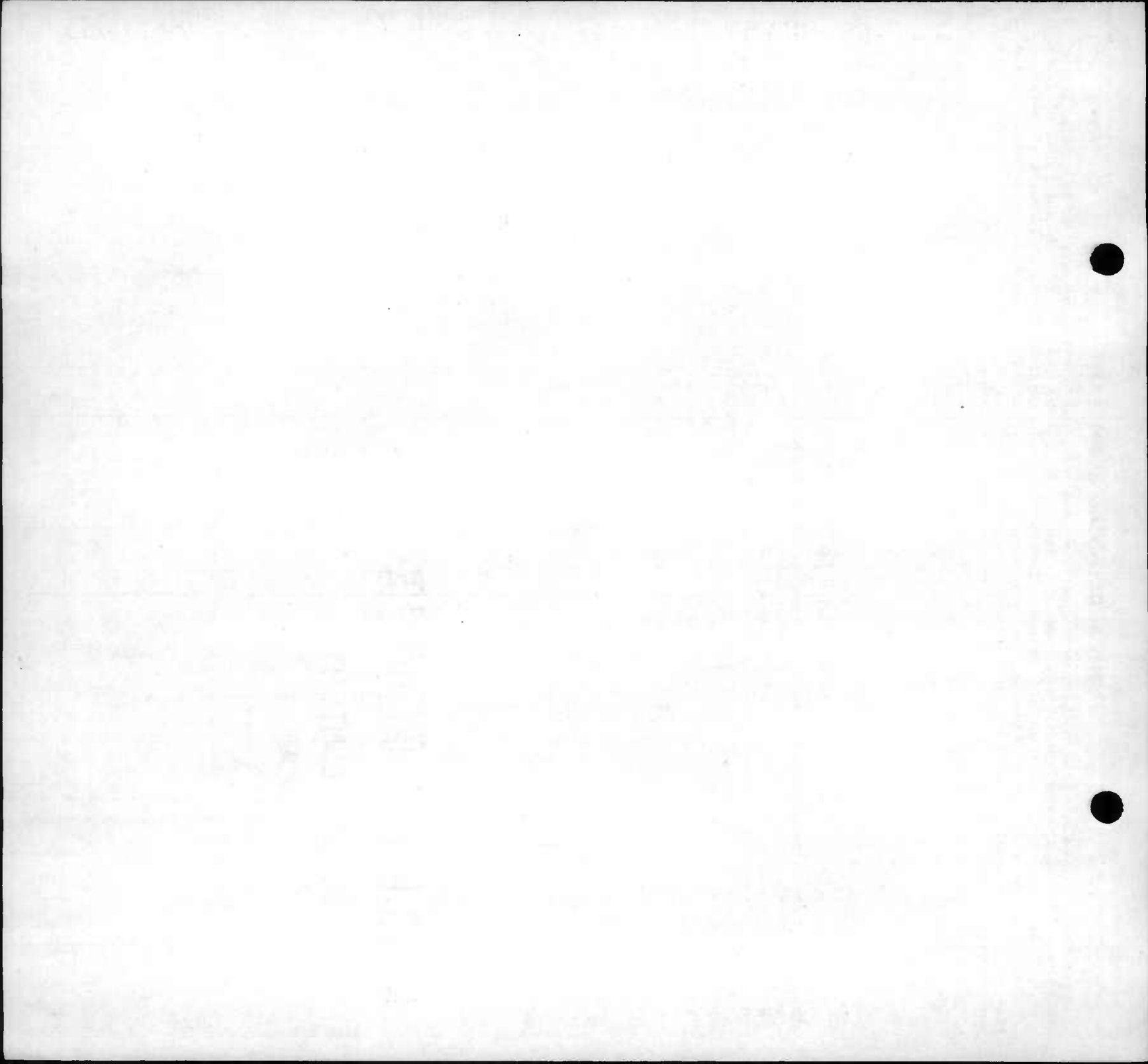
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0664	
BIRTH NO. 65 0664							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) George William H. Stegmann		2. DATE AND HOUR OF DEATH 1/16/65 1:45AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		A. STATE MD.				B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				53-00	
		D. STREET ADDRESS (If rural, give location) 728 Dunkirk Road					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 5/2/97	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Sears Roebuck Co		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Martin Stegmann				14. MOTHER'S MAIDEN NAME Anna Dove			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. W.W.I. 213-09-7578A		17. INFORMANT Elsie J Zench		ADDRESS 728 Dunkirk Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema		CAUSE OF DEATH (A) DUE TO Carcinoma of head of pancreas				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO					
(C) _____							
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema					
		19A. DATE OF OPERATION 1/13/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Nat While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/13 19 65 to 1/16 19 65 , that (I) (we) last saw the deceased alive on 1/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Philip A. Insley, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/16/65	
23C. PHYSICIAN'S NAME (Type) Philip A. Insley, Jr.				23D. ADDRESS MD. General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-19-65		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Insley, M.D.		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME		ADDRESS BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0665				
BIRTH NO. 65 0665					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) EMMA MAY LEE					2. DATE AND HOUR OF DEATH 1-17-65 3⁴⁵ A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION Memorial Hospital					A. STATE MARYLAND				
					B. COUNTY 26-03				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 311 MAYFIELD AVENUE				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 9-07-09	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM S. LEE					14. MOTHER'S MAIDEN NAME MARY DONAHUE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -			16. SOCIAL SECURITY NO. -		17. INFORMANT Chart - Union Memorial Hospital				ADDRESS
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) DUE TO massive hemorrhage, right cerebral hemorrhage & rupture into right lateral ventricle & increased intracranial pressure (B) DUE TO pressure (C) degenerated cerebral arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH	
					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary artery & right & left ventricular hypertrophy intermittent massive pulmonary edema				
19A. DATE OF OPERATION D			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that the (this hospital) attended the deceased from 1-16 1965 to 1-17 1965 , that we (we) last saw the deceased alive on 1-17 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) not view the body after death.									
23A. SIGNATURE Lawrence J. Lieberman					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-17-65	
23C. PHYSICIAN'S NAME (Type) Lawrence J. Lieberman					23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY Baltimore			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965			25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR William Samuel Horn 4210 Belair			ADDRESS



1
N. 160

65 0666

BALTIMORE CITY HEALTH DEPARTMENT

65 0666

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

59336

1. NAME OF DECEASED
(Type or Print)

HERMAN NEEPER

2. DATE AND HOUR PRONOUNCED DEAD

January 16, 1965 9:35 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1204 Beechwood Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 7, 1902

9. AGE (In years last birthday)

63 62

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Crane operator

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Neeper

14. MOTHER'S MAIDEN NAME

Fannie Herman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-07-3912

17. INFORMANT

ADDRESS

Mrs. Ethel Neeper 1204 Beechwood Road 21219

18.

422.11

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/19/65

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

(State)

Overlea, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2112 Dundalk Ave.

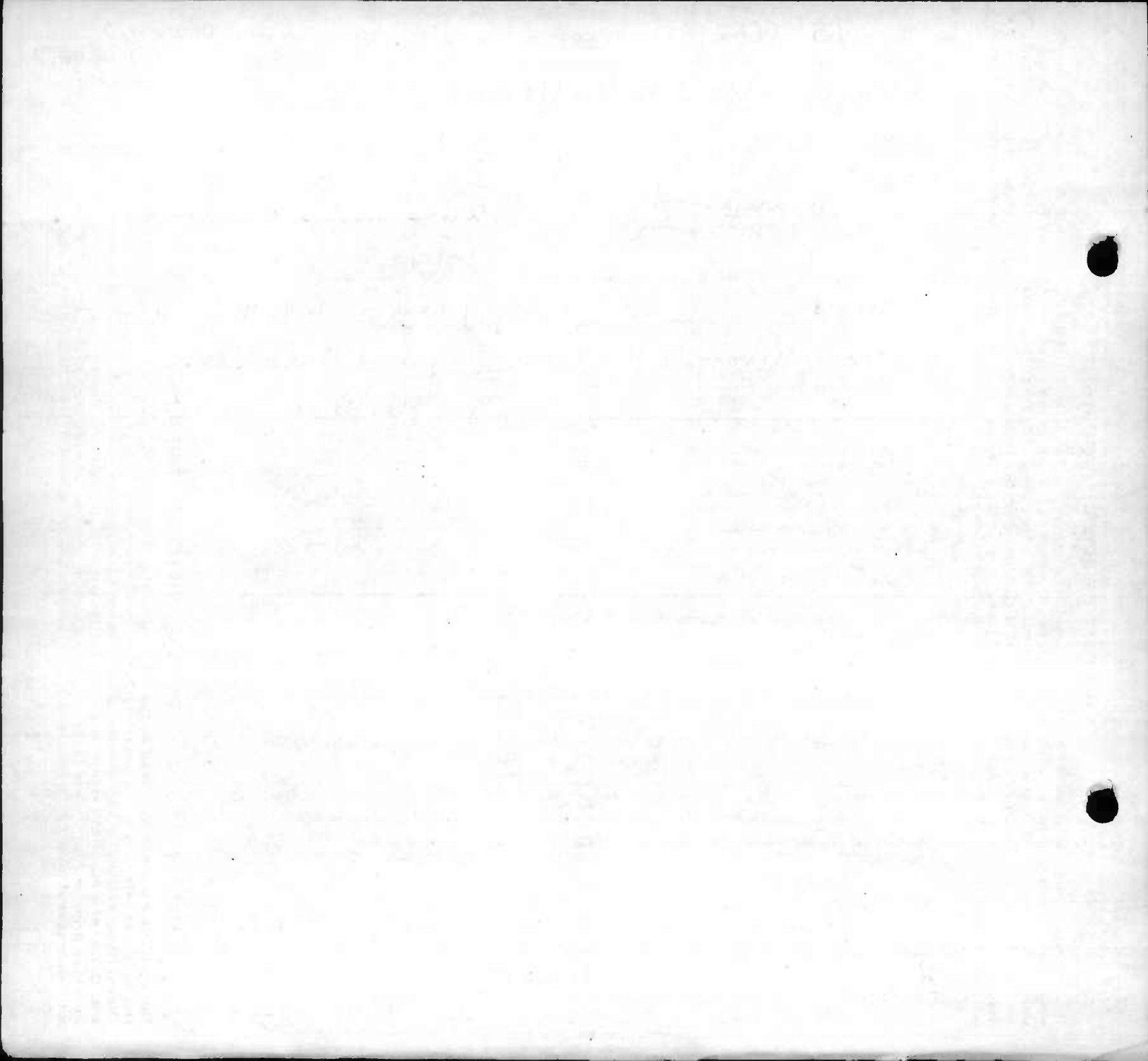
VALLEY FORGE

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0667					CERTIFICATE OF DEATH		Registered No. 102-965		
M.E. CASE NO.					65 0667				
1. NAME OF DECEASED (Type or Print) <i>John Keefer Dean Williams</i>					2. DATE AND HOUR OF DEATH <i>1-16 18:15 A</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Hospital for the Women of Maryland</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>15-38</i>				
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)					8. DATE OF BIRTH <i>3-9-1880</i>		9. AGE (In years last birthday) <i>84</i>		10. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Frederick Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Anthony Rummell Williams</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Ann Dean</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. W. Penley</i>		ADDRESS <i>Balto Md 2605 Elsinore Ave</i>
18. <i>422,19-159X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO <i>Myocardial Heart Failure</i> (B) DUE TO <i>2° Arteriosclerotic Cardiovascular Disease</i> (C) <i>Chronic Disease</i>				INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Carcinoma of the gastrointestinal tract.</i>									
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> 19 <i>65</i> to <i>Jan 16</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>8:15 AM 1-16-19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Angelita Toppan</i>					M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1-16-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>ANGELITA TOPPAN</i>					23D. ADDRESS <i>Women's Infirmary, Balto Md</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-19-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. OLIVET</i>		24D. LOCATION (City, town, or county) (State) <i>FREDERICK, MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>		25C. FUNERAL DIRECTOR <i>JOHN O. MITCHELL & SONS</i>			ADDRESS <i>1900 EUTAW PLACE BALTO. MD.</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. ON APPROVAL		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 0668		YES		65 0668	
M.E. CASE NO. 59333		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JEANETTE BYERS BURRIS		1-16-65		8:50 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON			
		D. STREET ADDRESS (If rural, give location) 311 LENOX AV3.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12/25/1884	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
		11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 473-80-8333	17. INFORMANT Helen Hughes - 823 N. Caroline St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH HYPOTHERMIA EXPOSURE SELF NEGLECT Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 311 Lenox Ave.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Jan 1 16 05 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? self-willed unheated home-exposure	
22. I certify that (I) (this hospital) attended the deceased from 1:00 P 1-16 19 65 to 8:50 1-16 19 65, that (I) (we) lost saw the deceased alive on JANUARY 16, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Lesch				23B. DATE SIGNED 1-16-65	
23C. PHYSICIAN'S NAME (Type) MICHAEL LESCH				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/21/65		Pleasant Rest	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Charles Whitman - 1701 Mt. Cumber	
				Baltimore, Md.	

UNITED STATES DEPARTMENT OF THE INTERIOR

1900

SELF REPORT

1900

JANUARY 10, 1900

UNITED STATES DEPARTMENT OF THE INTERIOR

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BALTIMORE CITY HEALTH DEPARTMENT

65 0669

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59309

1. NAME OF DECEASED (Type or Print) KOLMAN GRAY 2. DATE AND HOUR PRONOUNCED DEAD January 12, 1965 11:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2408 Roslyn Avenue

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH Dec. 23, 1937 9. AGE (In years lost birthday) 28

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Gray 14. MOTHER'S MAIDEN NAME Elsie Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. 2 16. SOCIAL SECURITY NO. 17. INFORMANT Elsie Carter ADDRESS 2408 Roslyn Ave

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2318 Division St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 11 64 ? 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Aspirated stomach contents precipitated by drinking.

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenacker CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 1-18-65 23C. NAME of CEMETERY or CREMATORY Baltimore Nat'l. Cent. 23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. JAN 20 1965 24B. NAME OF REGISTRAR Robert E. Taylor 24C. FUNERAL DIRECTOR ADDRESS 512 N. Carrollton Ave

VS 151-REV. 1/1/65 N 935.0

WALLEY FIDUCIARY

AMOUNT

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

100.00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0670

BIRTH NO. 65 0670

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN R. McFAUL

2. DATE AND HOUR OF DEATH

JAN. 18, 1965

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

BALTO. CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD.

26-09

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

3814 FAIT AVE.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12/9/08

9. AGE (in years last birthday)

56

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BELFORT INSTRUMENT CO. MD.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN McFAUL

14. MOTHER'S MAIDEN NAME

ANNA DONOHUE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-03-4209

17. INFORMANT

MRS. MIRIAM McFAUL

ADDRESS

3814 FAIT AVE.

18.

4-20-1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Emphysema

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

11/21

1961 to

1/18

1965

that (I) (we) last saw the deceased alive on

1/11

1965

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph Touhey

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1/19/65

23C. PHYSICIAN'S NAME (Type)

T. JOSEPH TOUHEY

23D. ADDRESS

441 S. ELLWOOD AVE.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/22/65

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION (City, town, or county)

BALTO. CO.

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

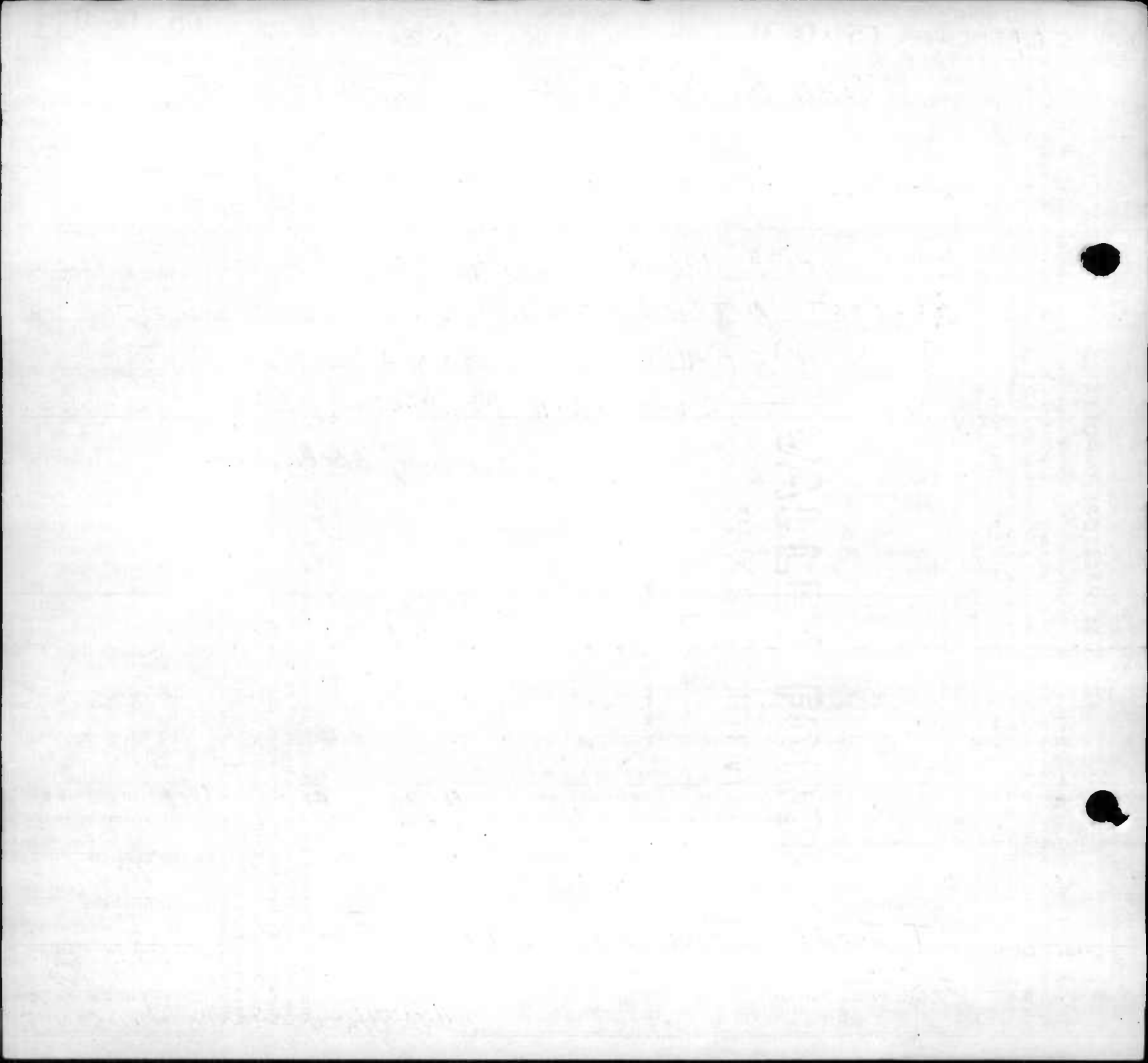
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

G.W. Hoffmann 3218 HUDSON ST.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0671

BIRTH NO. 65 0671

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

TUTT, JOHN B. JR

2. DATE AND HOUR OF DEATH

January 15, 1965 9:45 P.

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1132 Barclay Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9/12/14

9. AGE (In years last birthday)

50

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Sutt SR

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no.

16. SOCIAL SECURITY NO.

17. INFORMANT

Matel Sutt

ADDRESS

Same

18. 199-2-1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Carcinoma DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 15 1965 to Jan. 15 1965, that (I) (we) last saw the deceased alive on Jan. 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Manuel A. Gongon

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Jan. 15, 1965

23C. PHYSICIAN'S NAME (Type)

Manuel A. Gongon

23D. ADDRESS

M.D. 1400 N. Caroline Street

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

Burial 1/19/1965

24C. NAME OF CEMETERY or CREMATORY

McCahey Cmt

24D. LOCATION (City, town, or county)

Brooklyn

(State)

me

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Chas. W. Wilson - 1000 Brantly Ave

ADDRESS

James A. Smith

1
J. 520

65 0672

BALTIMORE CITY HEALTH DEPARTMENT

65 0672

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS JONES Jr

2. DATE AND HOUR PRONOUNCED DEAD

January 17, 1965 5:12 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 1234 E. Lafayette St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

March 4-1902

9. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Jones Sr

14. MOTHER'S MAIDEN NAME

Katie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Edna Sarah Jones

ADDRESS

Same

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/14/1965

23C. NAME OF CEMETERY or CREMATORY

Cornet

23D. LOCATION (City, town, or county)

Same

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Choy O. Wilson 1000 Brantley Ave

ADDRESS

WHEELLEY POLICE

MASTERS

U.S.A.

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

HARRISON YOUNG

2. DATE AND HOUR PRONOUNCED DEAD

January 17, 1965

10:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1316 Kenhill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1316 Kenhill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JAMES Young

14. MOTHER'S MAIDEN NAME

HATTIE HOPKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Aranelle Jackson 12274 Dallas St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) DUE TO Asphyxia
carbon monoxide inhalation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Garage

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Garage at rear of 1316 Kenhill Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1 18 65 Between

and 1 17 65 8:45 A. m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently inhaled carbon monoxide

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

R. Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/21/1965

23C. NAME of CEMETERY or CREMATORY

Salem Church CENT

23D. LOCATION

SALEM

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

E. O. Wilson

ADDRESS

1000 Brantley Ave

10

10

10

10

10

10

10

10

10

10

10

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. The text is mostly horizontal and spans the width of the page.]

[Handwritten signature or initials, possibly "M. J. ..."]

[Faint handwritten text at the bottom left, possibly "10-10-10"]

1
T 520

65 0674

BALTIMORE CITY HEALTH DEPARTMENT

65 0674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

59345

1. NAME OF DECEASED
(Type or Print)

JACOBIA THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

1-17-65

9:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2403 E. Lafayette Avenue 21213

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

August 5 1896

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cheraw South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Cash

14. MOTHER'S MAIDEN NAME

Jacobia Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Joseph Williams

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Peter W. Rieckert

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/13/1965

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cml

23D. LOCATION (City, town, or county)

Brooklyn

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

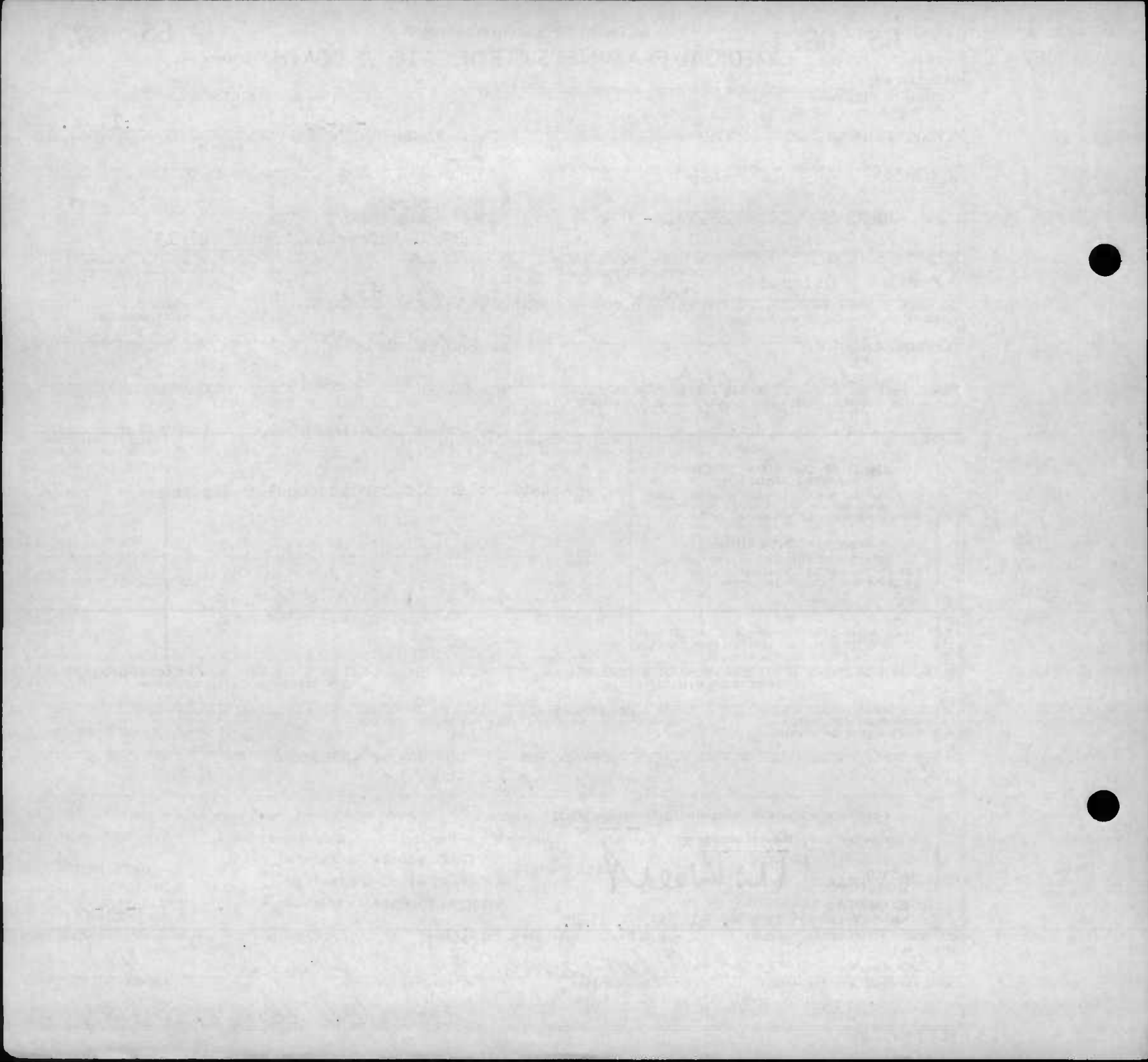
24B. NAME OF REGISTRAR

Robert E. Farber M.D.

24C. FUNERAL DIRECTOR

Choy A. Wilson on Brantly Ave

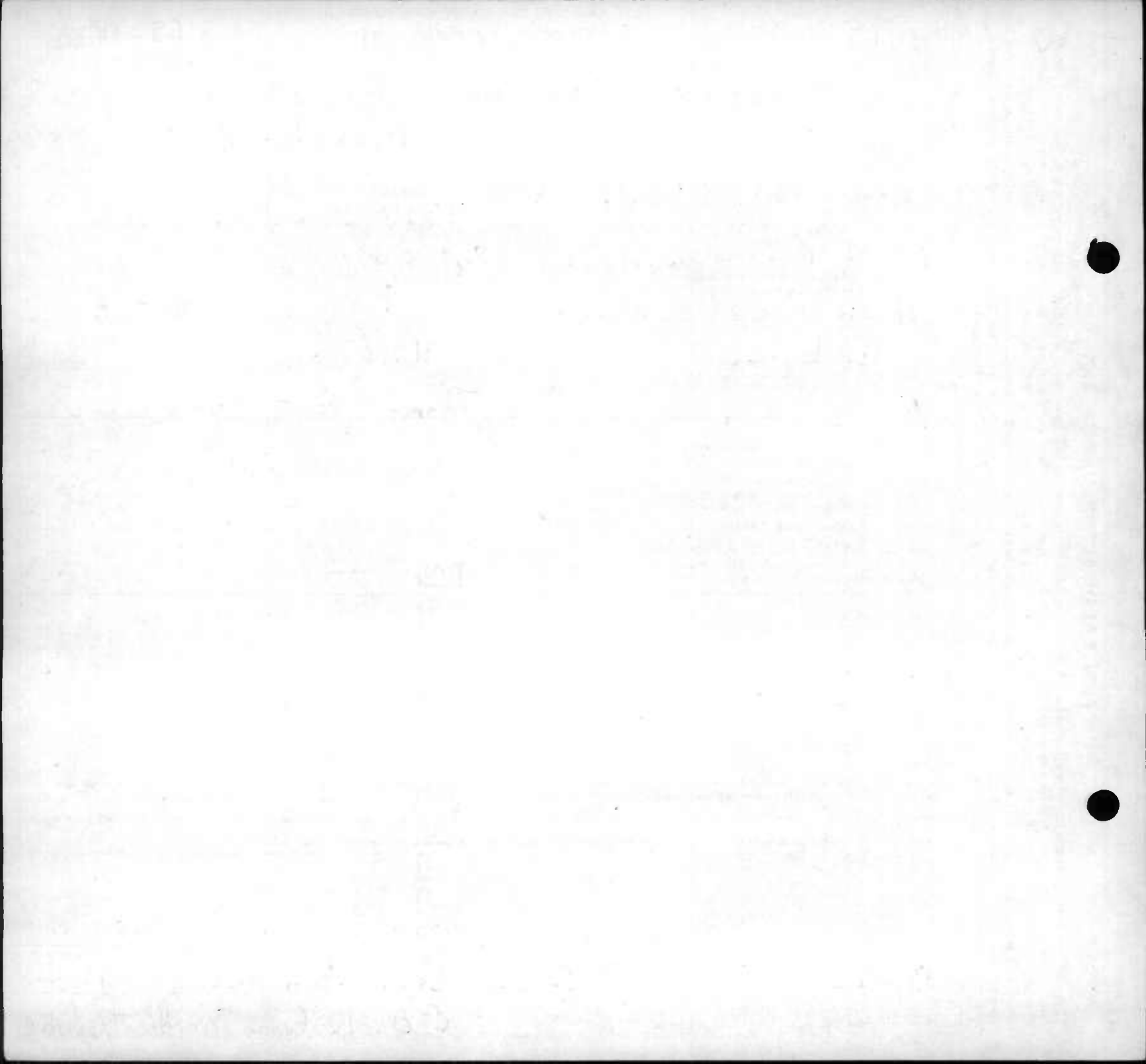
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0675</u>	
BIRTH NO. <u>65 0675</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Laura Mende</u>		2. DATE AND HOUR OF DEATH <u>Jan. 17, 1965 11:00 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Home - 3337 Windsor Ave.</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>15-47</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>3337 Windsor Ave.</u>	
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>		8. DATE OF BIRTH <u>Sept. 5, 1879</u>	9. AGE (In years last birthday) <u>85</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas Scott</u>		ADDRESS <u>115 N. Chapel St.</u>	
18. <u>332XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u>				CAUSE OF DEATH (A) DUE TO <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u>				(B) DUE TO <u>Arteriosclerosis</u>		?	
				(C) <u>Senility</u>		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>14 Jan 1965</u> to <u>17 Jan 1965</u> , that (I) (we) last saw the deceased alive on <u>16 Jan 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A.C. Burinell</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/19/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>A.C. BURINELL</u>				23D. ADDRESS <u>1924 W. North Ave Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. CALVARY Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Cedar Hill Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>C.O. Wilson</u>		ADDRESS <u>1000 Brantley Ave.</u>	



1
L-500

BALTIMORE CITY HEALTH DEPARTMENT

65 0676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0676

BIRTH NO.		M.E. CASE NO. 59342		1. NAME OF DECEASED (Type or Print) CROCKET CROCKETTON LANEY		2. DATE AND HOUR PRONOUNCED DEAD 1-17-65 11:36 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL - DOA				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 817 Elder Alley 21201			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-31-1896	9. AGE (In years last birthday) 66	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNK.				14. MOTHER'S MAIDEN NAME UNK.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James Laney 3705 Overview Rd.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter W. Rieckert</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-18-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-21-65		23C. NAME of CEMETERY or CREMATORY BALD. NAT'L		23D. LOCATION (City, town, or county) (State) BALD. Md. ✓	
24A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Morton & Dyett 916 Penna. Ave.			

WALLACE FORCE

WALLACE FORCE

2-21-1935

James L. Wallace

James L. Wallace

James L. Wallace

M. 600

BALTIMORE CITY HEALTH DEPARTMENT

65 0677

BIRTH NO.

65 0677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

59355

1. NAME OF DECEASED
(Type or Print)

RAYMOND MOORE

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965

10:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1721 Linden Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-28-1910

9. AGE (in years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Moore

14. MOTHER'S MAIDEN NAME

Dora Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James Moore 1405 Park Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Bronchial asthma

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-22-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat'l

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Morton + Dyett

ADDRESS

916 Penna Ave.

EXAMINATION OF THE

1. The first question is whether the evidence is sufficient to establish the fact of the crime.

2. The second question is whether the evidence is sufficient to establish the fact of the crime.

3. The third question is whether the evidence is sufficient to establish the fact of the crime.

4. The fourth question is whether the evidence is sufficient to establish the fact of the crime.

5. The fifth question is whether the evidence is sufficient to establish the fact of the crime.

6. The sixth question is whether the evidence is sufficient to establish the fact of the crime.

7. The seventh question is whether the evidence is sufficient to establish the fact of the crime.

8. The eighth question is whether the evidence is sufficient to establish the fact of the crime.

9. The ninth question is whether the evidence is sufficient to establish the fact of the crime.

10. The tenth question is whether the evidence is sufficient to establish the fact of the crime.

11. The eleventh question is whether the evidence is sufficient to establish the fact of the crime.

12. The twelfth question is whether the evidence is sufficient to establish the fact of the crime.

13. The thirteenth question is whether the evidence is sufficient to establish the fact of the crime.

M. 624
H. 252

65 0678

BALTIMORE CITY HEALTH DEPARTMENT

65 0678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

59344

1. NAME OF DECEASED

(Type or Print)

AGNES MARSHALL ((Hawkins))

2. DATE AND HOUR PRONOUNCED DEAD

1-17-65

3:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

320 Worsley Street - 21218

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Wid.

8. DATE OF BIRTH

Aug. 14, 1894

9. AGE (in years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charles Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unk

14. MOTHER'S MAIDEN NAME

Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wm. Marshall 113 Fleming Drive

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute ethylism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-21-65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Morton & Dyett Funeral Home, Inc.
916 Pennsylvania Ave. Balto., Md.

ADDRESS

WALLEY FORDGE

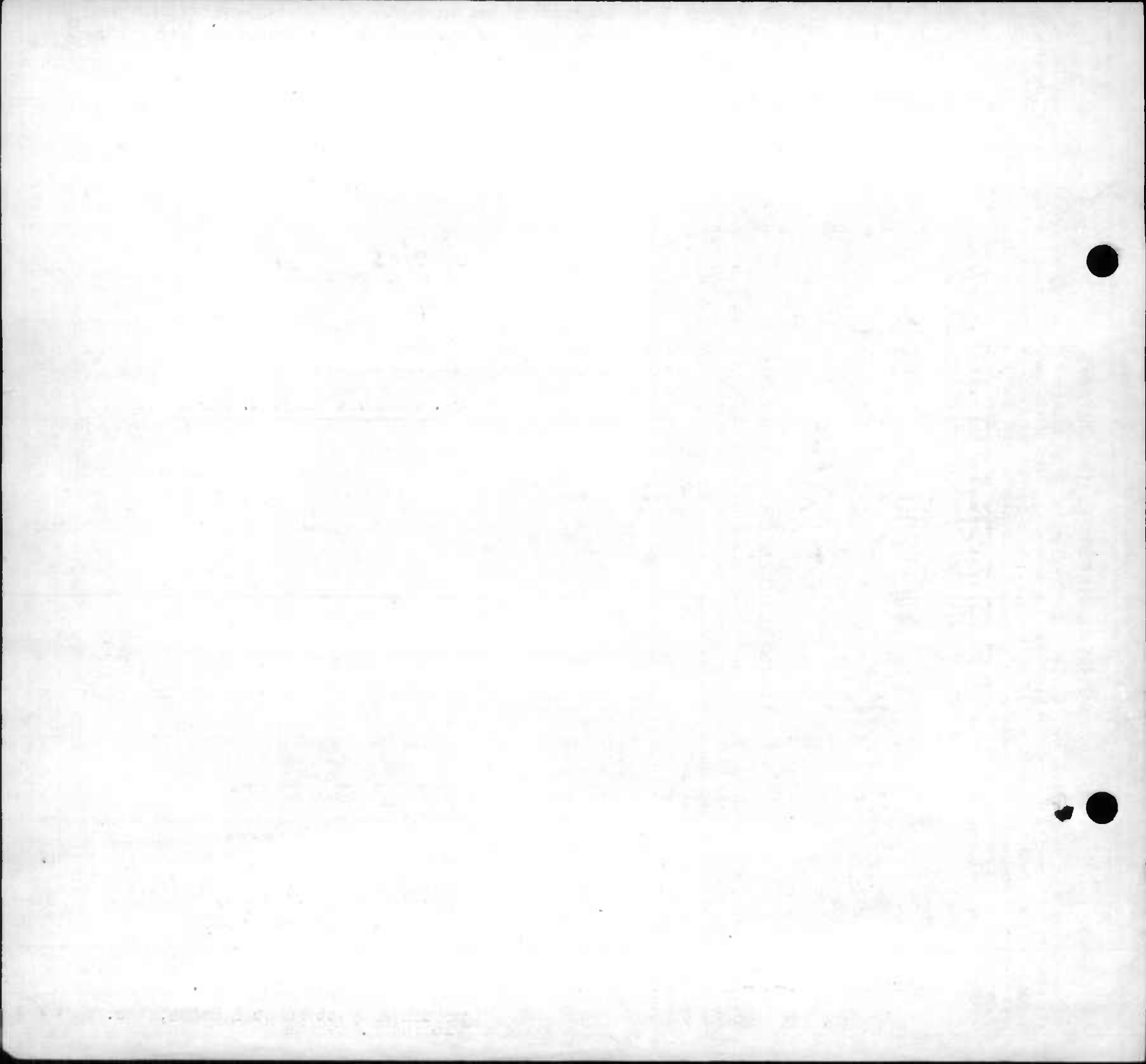
NO COMMENT

12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No. 65 0679	
BIRTH NO. 65 0679											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Irene Trotters						2. DATE AND HOUR OF DEATH 1/18/65 1:15 PM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1101 Orleans ST.					
5. SEX F		6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 6/4/03		9. AGE (In years last birthday) 61		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Booz						14. MOTHER'S MAIDEN NAME Sarah Taylor					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Michaels 1935 W. North Avenue ADDRESS					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypernephroma Left Kidney						INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1/18 19 64 to 1/18 19 65, that (1) (we) lost saw the deceased alive on 1/18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Frank M. Houston M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) FRANK M. HOUSTON						23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-22-65		24C. NAME OF CEMETERY or CREMATORY National				24D. LOCATION (City, town, or county) Baltimore (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR Morton & Dyett Funeral Homes, Inc. 916 Penna. Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

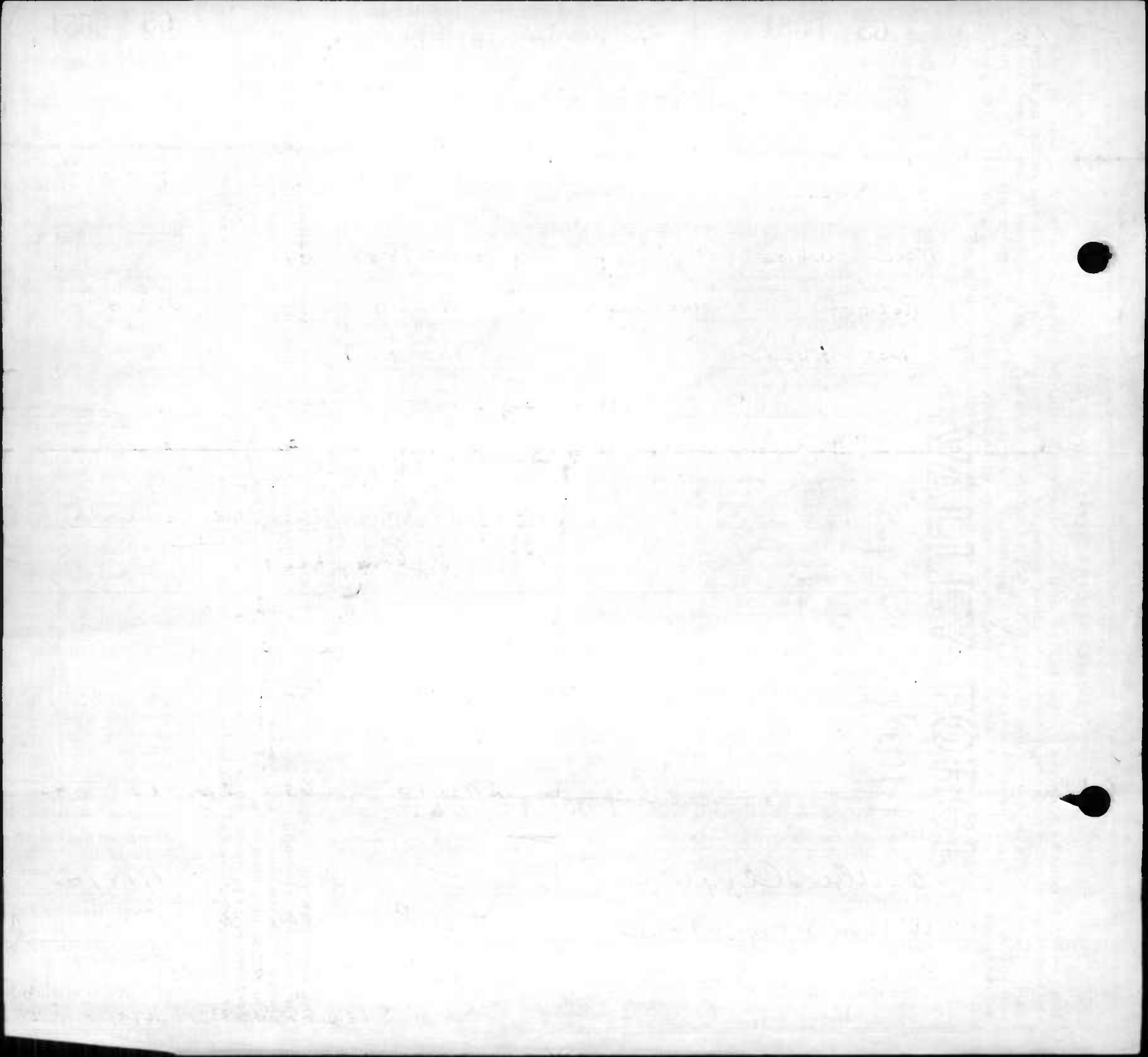
BIRTH NO. 65 0680		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0680	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) EDWARD KELLY				1/18/65N 12:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND B. COUNTY 10-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 1116 N. EDEN ST.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/24/98	9. AGE (In years) lost his 66	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY Mr. Cork & Seal		11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME NELSON KELLY			14. MOTHER'S MAIDEN NAME CLARA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 216-01-2942		17. INFORMANT Ellen Kelly		
					ADDRESS 1116 N. Eden St.		
18. 570.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Septic Negative Sepsis DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION 1/18/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED R/O MESENTERIC THROMBOSIS		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/17 19 65 to 1/18 19 65 , that (I) (we) last saw the deceased alive on 1/18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R. Wagner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/15/65	
23C. PHYSICIAN'S NAME (Type) JOHN R. WAGNER				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-21-65		24C. NAME OF CEMETERY or CREMATORY BALTO. NAT'L		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton Dyett		ADDRESS 916 PENNA AVE. #1	

00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 0681					
BIRTH NO. 65 0681					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>WILLIAM FARBER</u>					2. DATE AND HOUR OF DEATH <u>JAN. 19, 1965</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>BELUGDERE NURSING HOME</u>					A. STATE <u>FLORIDA</u>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>MIAMI BEACH</u>					
					D. STREET ADDRESS (If rural, give location) <u>V-08</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>12-15-1880</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>NOT KNOWN</u>					14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>244-48-9003</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>			ADDRESS		
18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Failure</u> <u>Congestive Heart Failure</u> <u>Cerebral Vascular Hemorrhage</u> <u>Arteriosclerotic Cerebral</u> <u>Chronic Pyelonephritis</u>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>JAN 10</u> 19 <u>65</u> to <u>JAN 19</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>JAN 19</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>William Applefeld</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/15/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM APPLEFELD</u>					23D. ADDRESS M.D. <u>5507 Park Heights Dr. - Balto 15th</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>1/20/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>			24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>			25C. FUNERAL DIRECTOR <u>SYLVAN S. LEWIS & SON</u>			ADDRESS <u>3319 OLYMPIA AVE.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 65 0682

BIRTH NO.

65 0682

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ada Solomon

2. DATE AND HOUR OF DEATH

1/17/65 500

A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where Deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE CITY

D. STREET ADDRESS (If rural, give location)

208 HERRING COURT

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

8-7-08

9. AGE (In years
last birthday)

56

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Lynchburg, S. C.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Frank Fortune

14. MOTHER'S MAIDEN NAME

Ada Henry

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Vera Carpenter

ADDRESS

327 MANNING Ave
Smyth S. C.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Mitral insufficiency with
intractable heart failure
Rheumatic heart disease
with Severe Pulmonary HypertensionINTERVAL BETWEEN
ONSET AND DEATH2 1 yr
Many yrs

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Indicate medical examination)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/19/64 1964 to 1/17 1965
that (I) (we) last saw the deceased alive on 1/6 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Willis C. Maddrey

M.D.

Attending
Phys.Mod.
DirectorStaff
Phys.

23B. DATE SIGNED

1/17/65

23C. PHYSICIAN'S
NAME (Type)

WILLIS C. MADDREY

M.D.

23D. ADDRESS

Johns Hopkins Hosp. Balt Md

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-20-65

24C. NAME of CEMETERY or CREMATORY

MT. CALVARY Cem.

24D. LOCATION

Brooklyn,

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1965

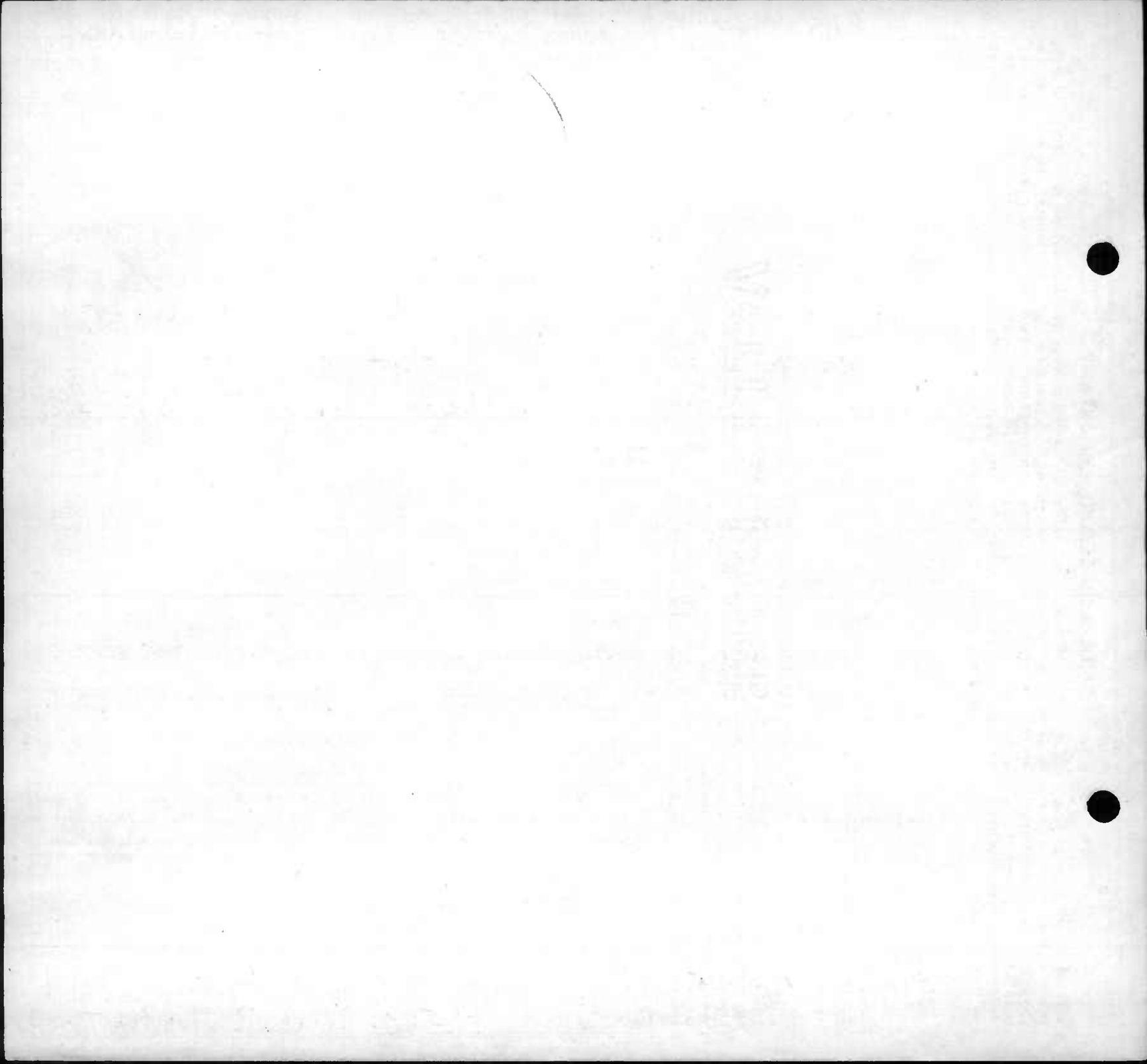
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

E. O. Wilson 1000 Brantley Ave

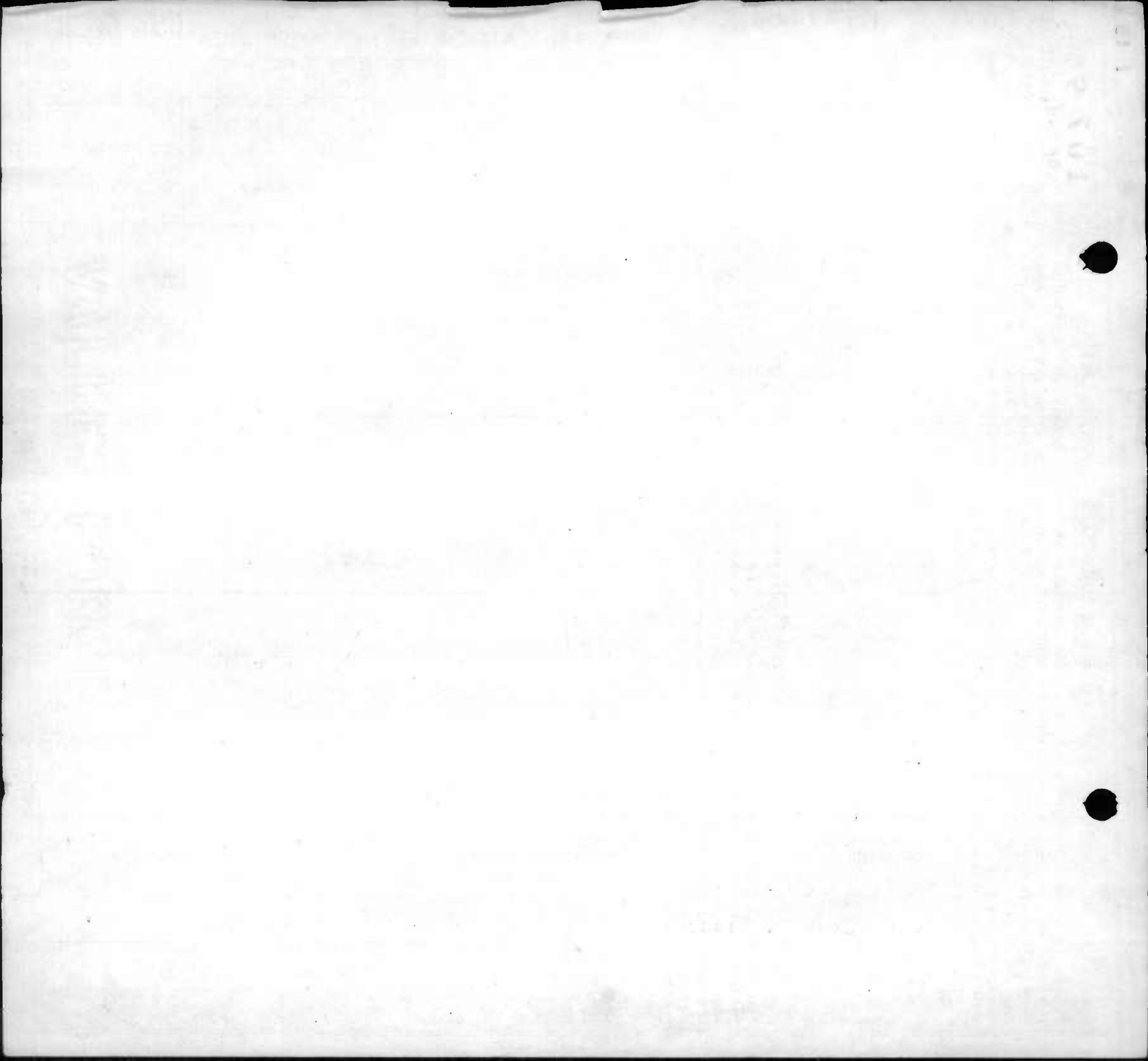
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

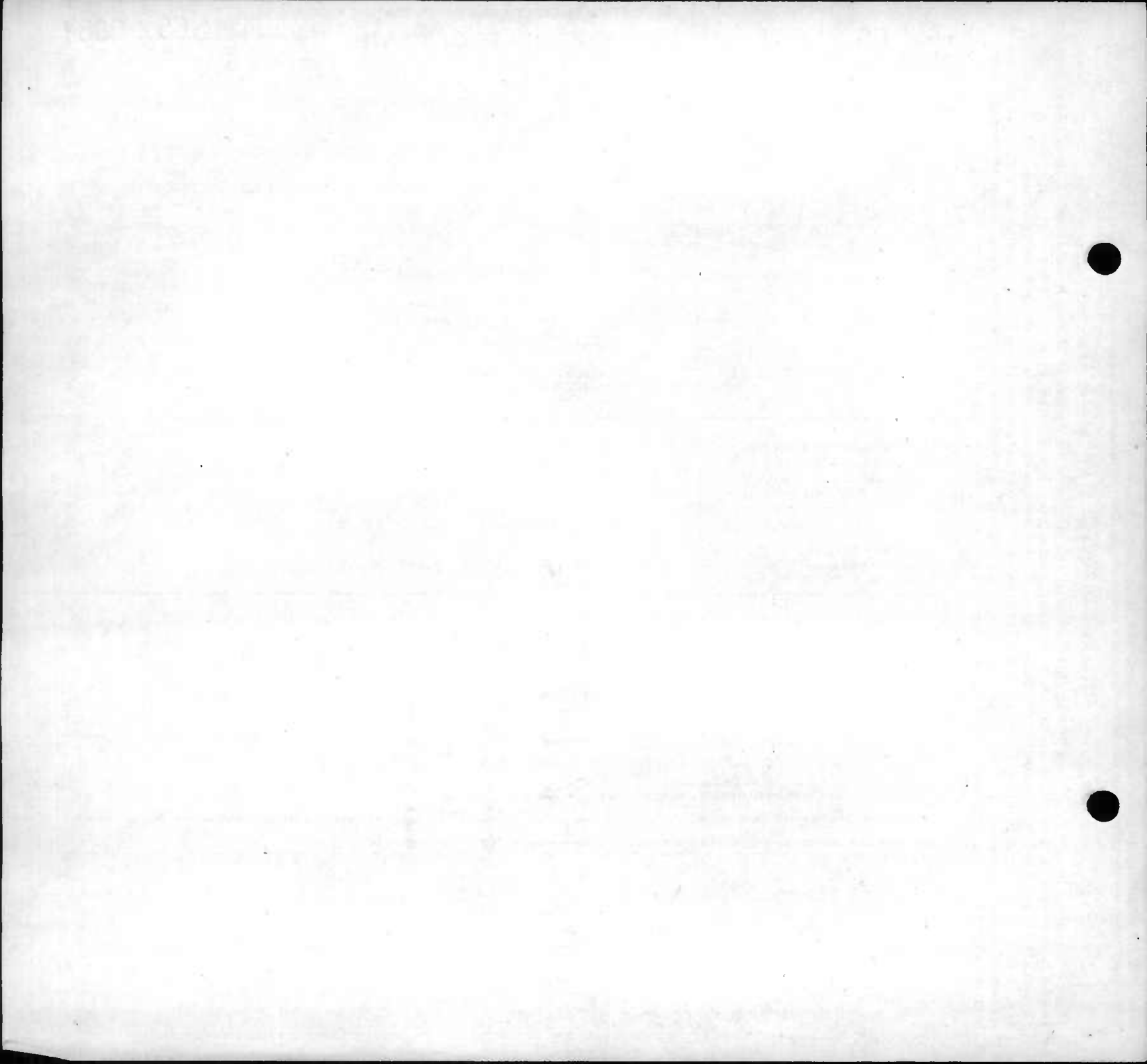
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0683	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0683					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) GORDON, THOMAS L.		2. DATE AND HOUR OF DEATH 1-18-65 5⁰⁰ am			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		A. STATE Md B. COUNTY 8-06			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1714 N. BROADWAY			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12/25/94	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10B. KIND OF BUSINESS OR INDUSTRY Apartment Bldg.		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Susan Gordon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 084-03-9469		17. INFORMANT PEARL GORDON 1714 Broadway	
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Uremia		3 mos.	
		(C) Carcinoma of prostate		15 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12 19 65 to 1-18 19 65 , that (I) (we) last saw the deceased alive on 1-18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Bigger, Jr. MD				23B. DATE SIGNED 1-18-65	
23C. PHYSICIAN'S NAME (Type) JOHN F. BIGGER				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cems.	
				24D. LOCATION (City, town, or county) (State) A.A. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Charles B. Lewis 839 Mt. Holly St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT													
BIRTH NO. 65 0684										CERTIFICATE OF DEATH		Registered No. 65 0684	
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) Cecil H. Ravenscroft						2. DATE AND HOUR OF DEATH Jan. 19/65 10:45 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 20-03							
FULL NAME OF HOSPITAL OR INSTITUTION 27 S. Payson St.						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Barto. 23							
D. STREET ADDRESS (If rural, give location) 27 S. Payson St.						E. CITY OR TOWN (If outside city limits, write RURAL and give township)							
5. SEX Male		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH April 3/1900		9. AGE (In years last birthday) 64		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Turner Md. Dry Block						10B. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (State or foreign country) Md						12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Robt Ravenscroft						14. MOTHER'S MAIDEN NAME Maude							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. 216-07-2591-Margaret Ravenscroft							
17. INFORMANT (Same)						ADDRESS							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 161X I CAUSE OF DEATH (A) CARCINOMA OF LARYNX DUE TO (B) GENERAL CARCINOMATOSIS DUE TO (C) PULMONARY METASTASES INTERVAL BETWEEN ONSET AND DEATH 5 YRS 6 MOS. 2 MOS.						II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. MAX NUTRITION 1 YR.							
19A. DATE OF OPERATION None						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20A. AUTOPSY? (Yes or No) No						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None							
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None						21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None							
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						21F. HOW DID INJURY OCCUR? None							
22. I certify that (I) (this hospital) attended the deceased from JAN. 4 1961 to JAN. 19 1965, that (I) (we) last saw the deceased alive on JAN. 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE Albert W. Wilkerson M.D.													
23B. DATE SIGNED 1/20/65													
23C. PHYSICIAN'S NAME (Type) HERBERT P. WILKERSON M.D.						23D. ADDRESS 1200 ST. PAUL ST. BARTO. -2, MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial						24B. DATE 1/22/65							
24C. NAME OF CEMETERY OR CREMATORY Lanston Pl						24D. LOCATION (City, town, or county) (State) Barto. Md							
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965						25B. NAME OF REGISTRAR Robert E. Taylor M.D.							
25C. FUNERAL DIRECTOR Walter F. D. 4101 Edmondson						ADDRESS							



1
D-520

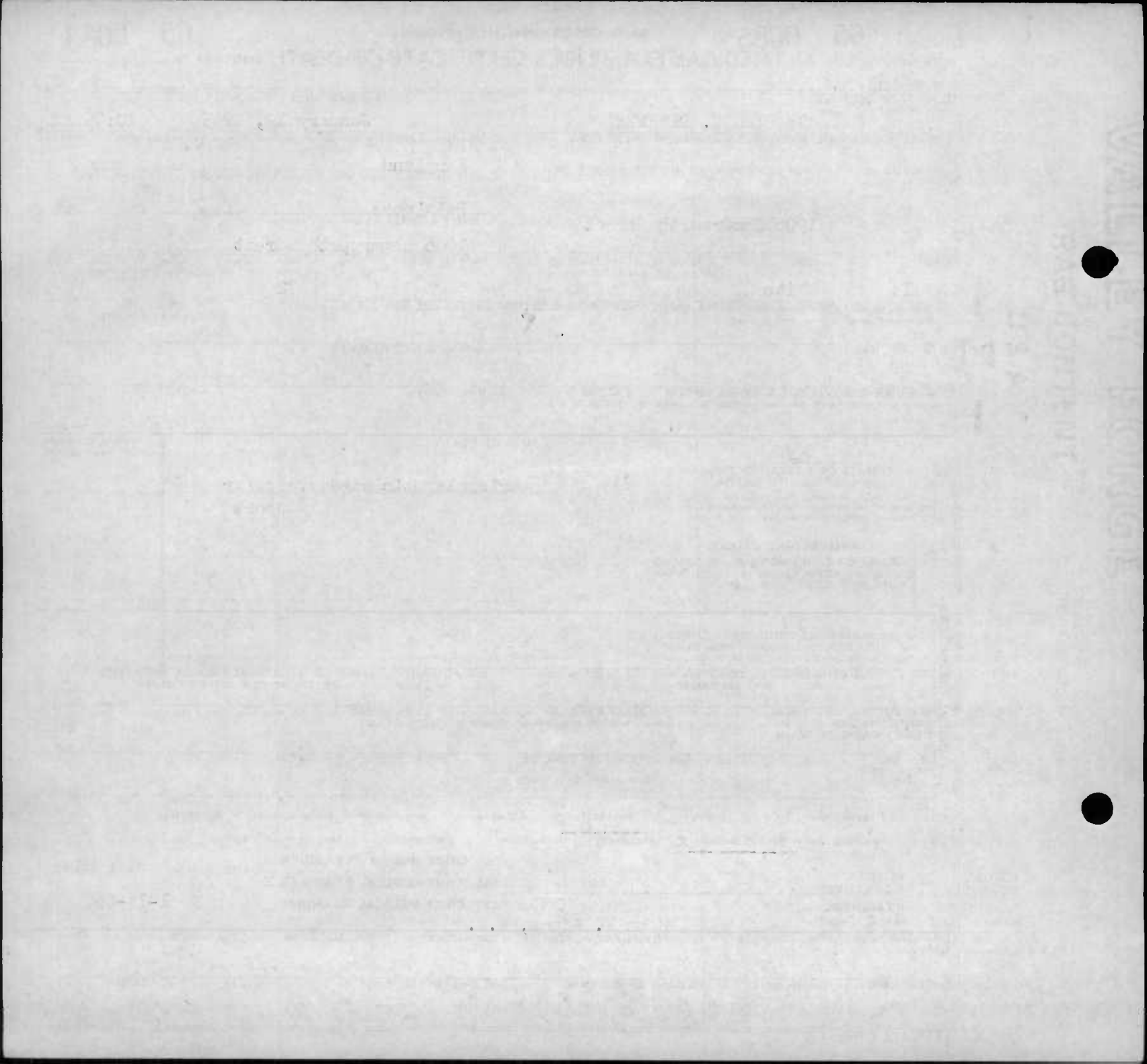
65 0685
M.E. CASE NO. 59363

BALTIMORE CITY HEALTH DEPARTMENT

65 0685

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

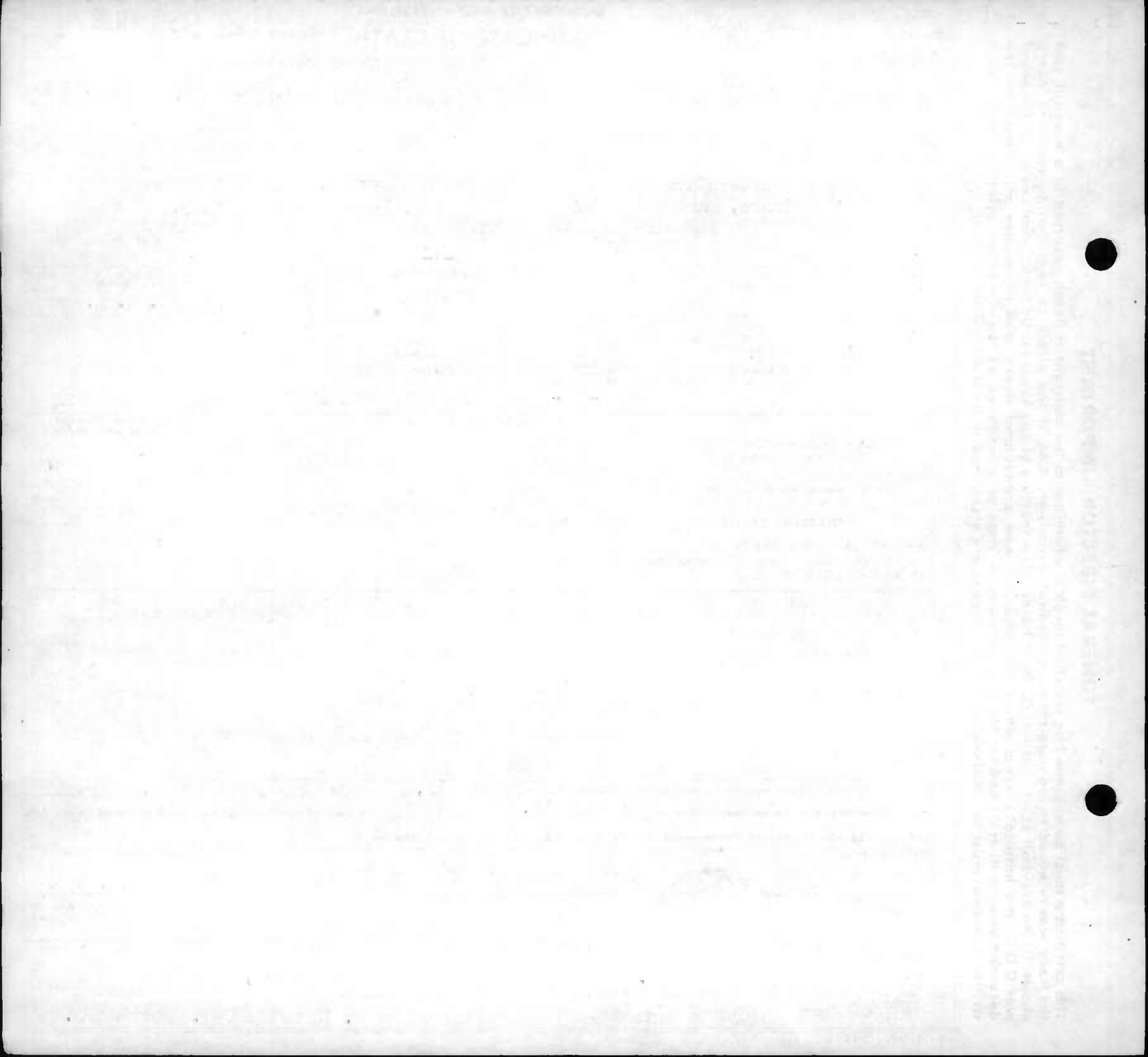
1. NAME OF DECEASED (Type or Print) CHARLES C. DAEHNKE				2. DATE AND HOUR PRONOUNCED DEAD January 19, 1965 10:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1906 Somerworth Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 30 2-5-43 D. STREET ADDRESS (If rural, give location) 1906 Somerworth Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 10, 1892	9. AGE (In years last birthday) 72	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Daehnke			14. MOTHER'S MAIDEN NAME Adeline Schroeder				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 316-01-7319		17. INFORMANT ADDRESS Mrs. Agnes M. Daehnke		
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John E. Adams M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-19-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Jan 22/65		23C. NAME OF CEMETERY or CREMATORY Meadowdale		23D. LOCATION (City, town, or county) (State) Harsey Md	
24A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS W. H. 4101 Edmondson			



1

65 0686		BALTIMORE CITY HEALTH DEPARTMENT		65 0686	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
JAMES JOHNSON			January 18, 1965 3:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
1010 W. Lanvale Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01		
			D. STREET ADDRESS (If rural, give location) 1010 W. Lanvale Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Negro	Never Married	March 5, 1941	23	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Paris C. Johnson			Annie Cotton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Paris C. Johnson 7 N. Catherine St.	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
Asphyxia drowning					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
Post-traumatic convulsive seizure					
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		1010 W. Lanvale Street 16-01	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) 1 18 65		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Apparently drowned in bathtub during convulsion	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		1-19-65	
John E. Adams, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		1/22/65		Mt. Auburn Cem.	
23D. LOCATION (City, town, or county)		23E. NAME OF REGISTRAR		23F. FUNERAL DIRECTOR ADDRESS	
Baltimore, Maryland		Robert E. Farber, M.D.		George A. Wilson 1348 N. Catherine St.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JAN 20 1965		Robert E. Farber, M.D.		George A. Wilson 1348 N. Catherine St.	

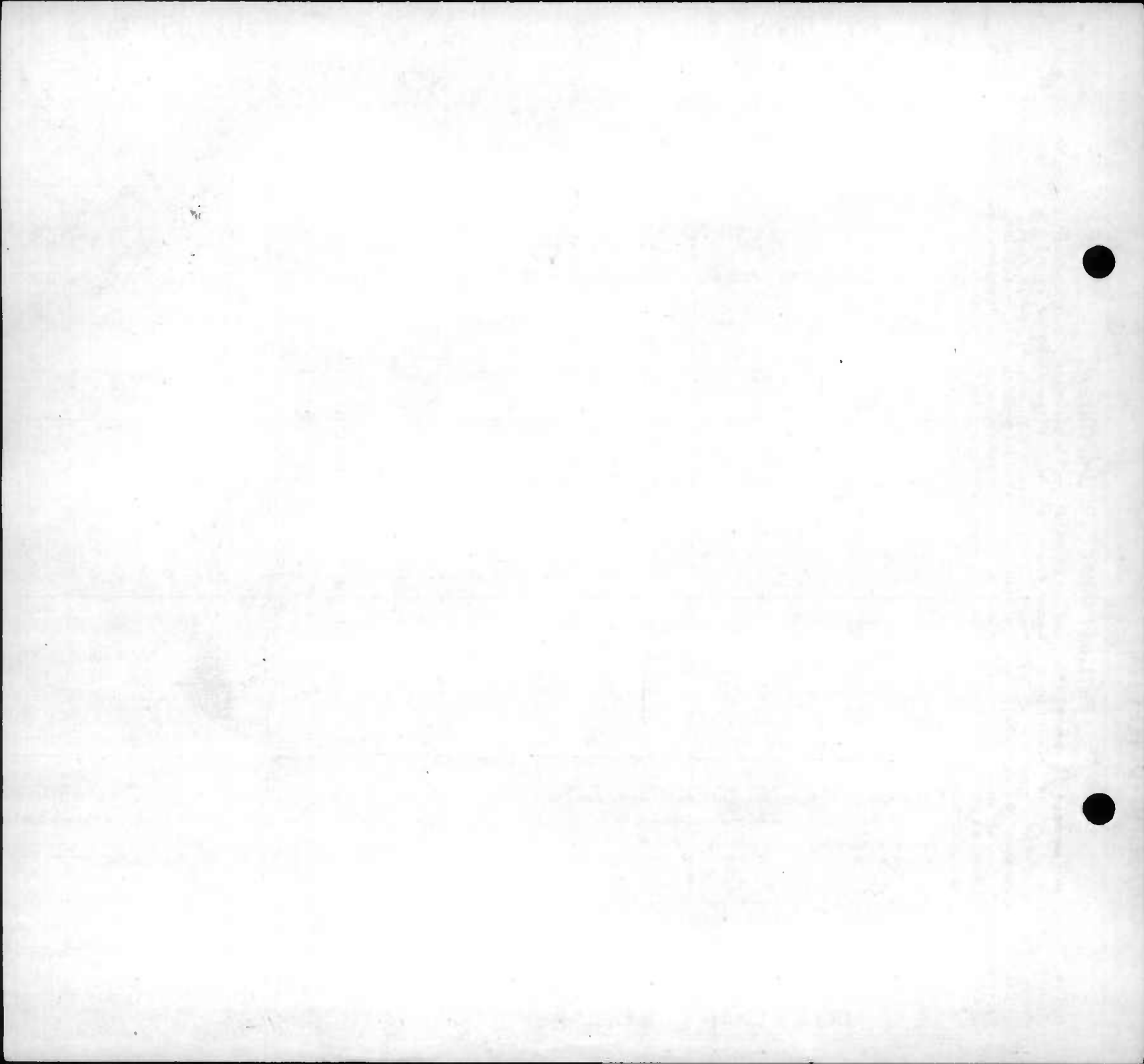
WILLIAM L. BRYAN
PRESIDENT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0688	
65 0688				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mabel Galloway	
2. DATE AND HOUR OF DEATH 1/18/65		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balt.	
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
8. DATE OF BIRTH 12/11/94		9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John F. Parks	
14. MOTHER'S MAIDEN NAME Martha Cockey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Family records		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) Rupture of aortic artery		2-3 minutes	
ANTECEDENT CAUSES		(B) Arterial catheterization, percutaneous and subsequent infection at site		2 weeks	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Carcinoma of left maxillary sinus		6 months	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/10/65 to 1/18/65		that (1) (we) last saw the deceased alive on 1/17/65		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Ronald Rice		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) Ronald Rice		23D. ADDRESS Sinai Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Parkville, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR John Burns Sons		ADDRESS 610-12 York Rd. Towson			



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

B. 530

65 0689

1. NAME OF DECEASED (Type or Print) **AUSTIN L. BENNETT**

2. DATE AND HOUR PRONOUNCED DEAD **1-18-65 10:10 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **4701 NORTH CHARLES STREET**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore 27-11**

D. STREET ADDRESS (If rural, give location) **4701 N. Charles Street - 21210**

5. SEX **Male**

6. RACE **White**

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) **Divorced**

8. DATE OF BIRTH **June 7, 1919**

9. AGE (In years last birthday) **45**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Caretaker**

10B. KIND OF BUSINESS OR INDUSTRY **Notre Dame College**

11. BIRTHPLACE (State or foreign country) **Maryland**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Jesse L. Bennett**

14. MOTHER'S MAIDEN NAME **Anna E. ?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes**

16. SOCIAL SECURITY NO. **215-14-5386**

17. INFORMANT **Family Records**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Extensive coronary sclerosis with multiple myocardial scars

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **Yes**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Peter W. Rieckert** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **PETER W. RIECKERT, M.D.** ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒ DATE SIGNED **1-18-65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

23B. DATE **Jan. 21, 1965**

23C. NAME OF CEMETERY or CREMATORY **Baltimore National Cemetery**

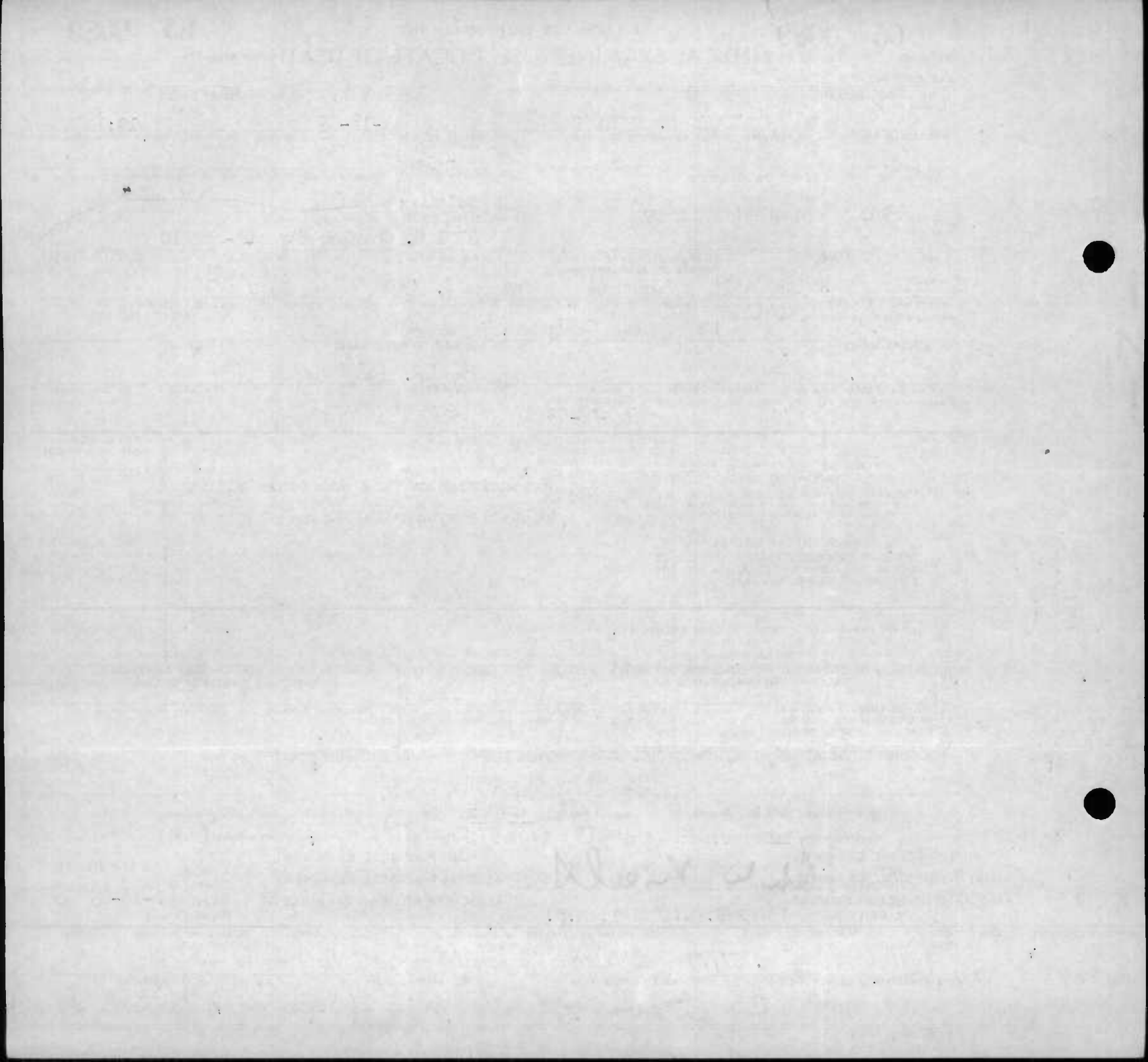
23D. LOCATION (City, town, or county) (State) **Baltimore, Maryland**

24A. DATE REC'D BY HEALTH DEPT. **JAN 20 1965**

24B. NAME OF REGISTRAR **Robert E. Fisher, M.D.**

24C. FUNERAL DIRECTOR **John Burns' Sons, Towson, Maryland**

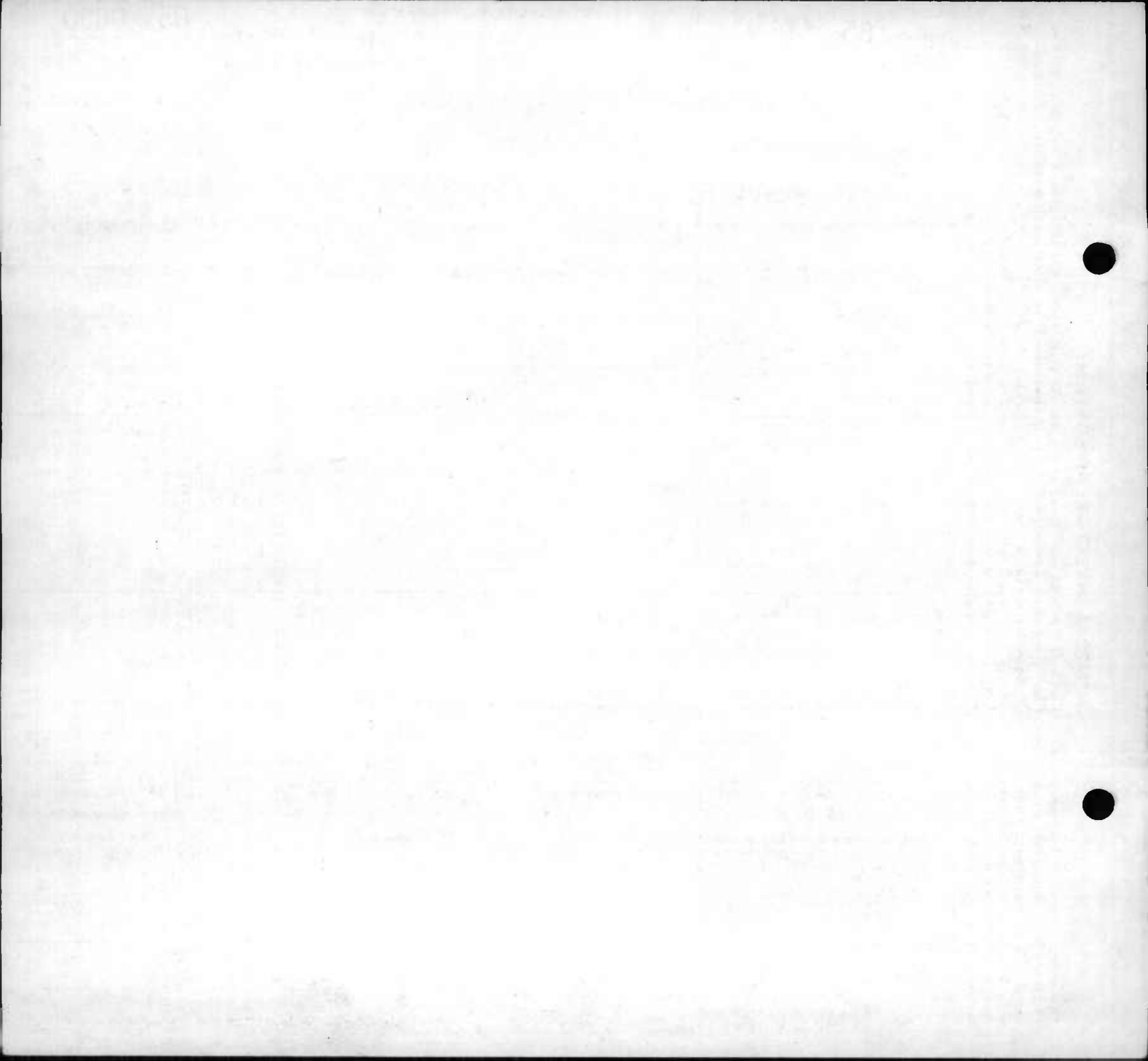
24D. ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

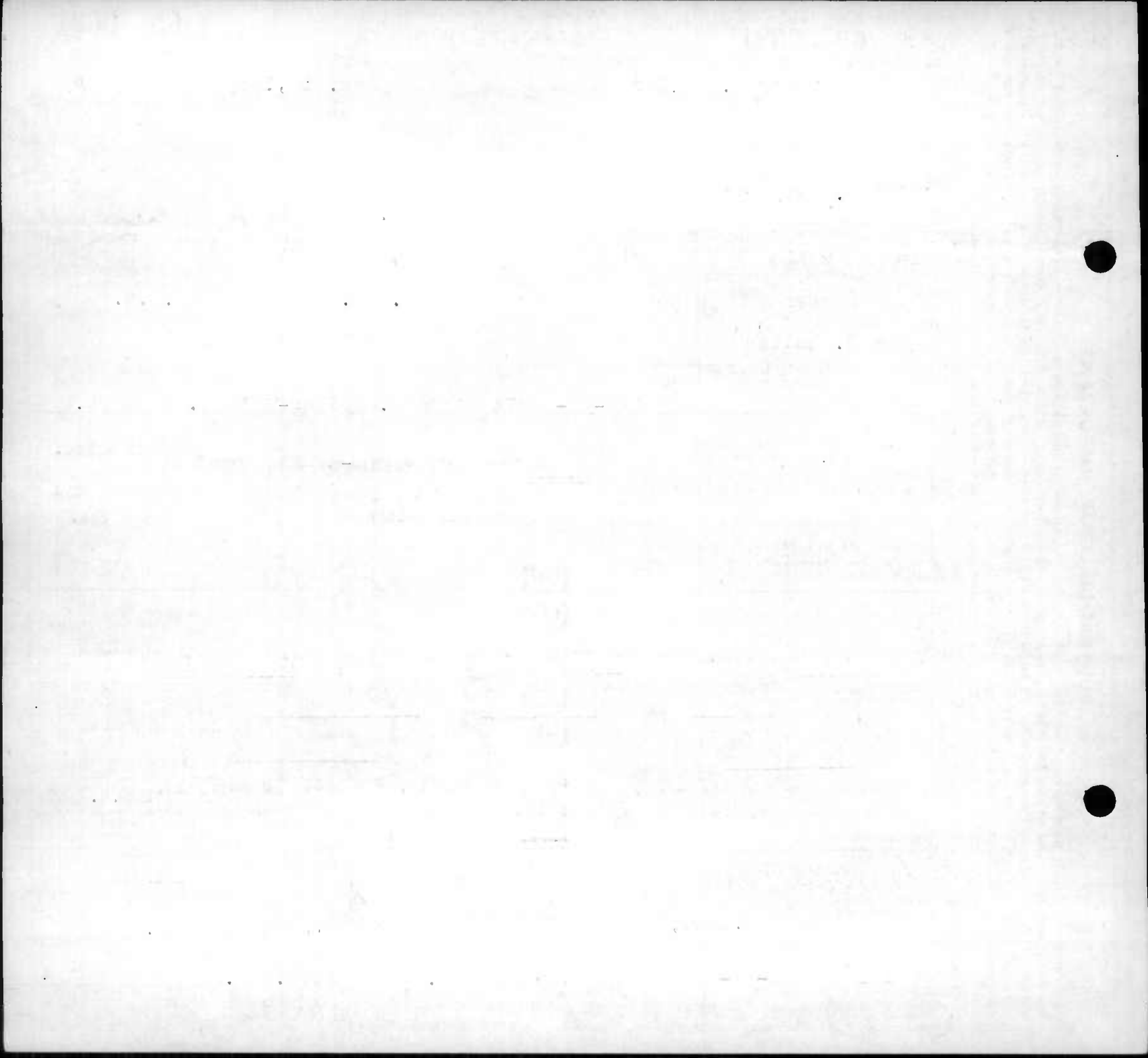
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 0690		Registered No. 65 0690									
M.E. CASE NO. SAMUELSON				CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) <u>LEVA Samuelson</u>				2. DATE AND HOUR OF DEATH <u>1/18/65</u> <u>1 35</u> M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3608 Calloway Ave</u>											
5. SEX <u>F</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-5</u>	9. AGE (In years last birthday) <u>85</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>MAY FLEISHMAN</u>				14. MOTHER'S MAIDEN NAME <u>FRUMA</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HERMAN SAMUELSON</u>		ADDRESS <u>SAME</u>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>(A) Gastrointestinal Hemorrhage from Stomach</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Acute Pulmonary Embolism</u>				INTERVAL BETWEEN ONSET AND DEATH											
								19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
								20A. AUTOPSY? (Yes or No) <u>No</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?											
22. I certify that (I) <u>(X)</u> (this hospital) attended the deceased from <u>1/18</u> 19 <u>65</u> to <u>1/18</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1/18</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.															
23A. SIGNATURE <u>Martin E. Symonsky</u> M.D.				23B. DATE SIGNED <u>1/18/65</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>									
23C. PHYSICIAN'S NAME (Type) <u>Martin E. Symonsky</u>				23D. ADDRESS <u>Sinai Hospital</u> M.D.											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/19/1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SOUTHERN AVE</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>SYLVESTER S. LEWIS & SON</u>		ADDRESS <u>3319 OLYMPIA AVE</u>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0691	
BIRTH NO. 65 0691		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lawrence J. Moller		2. DATE AND HOUR OF DEATH Jan. 18, 1965 1 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2037 E. 32nd Street				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2037 E. 32nd Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 27, 1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Keeper		10B. KIND OF BUSINESS OR INDUSTRY McInnes Laundry		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Moller				14. MOTHER'S MAIDEN NAME Bernadine Schaefer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-6957A		17. INFORMANT ADDRESS Anna M. Moller-2037 E. 32nd St.			
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH			
				(A) Hypertensive cardio-vascular renal disease DUE TO			
				Edema of the lungs DUE TO			
				Paralysis Agitans DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH About 4 Yrs. About 3 days About 8 Yrs.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 17, 1964 to January 18, 1965 , that (I) (we) last saw the deceased alive on January 15, 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death.							
23A. SIGNATURE Ernest G. Marr				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) Ernest G. Marr,				23D. ADDRESS M.D. 516 Cathedral St., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John G. Miller Inc - 6415 Belair Rd.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 0692	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0692					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Hilda Northman</i>		2. DATE AND HOUR OF DEATH <i>Jan. 16 '65 8:40 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Balto, Md.</i> B. COUNTY <i>27-02</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Md.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location) <i>2607 List Ave</i>			
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>June 24, 1903</i>	9. AGE (In years, lost birthday) <i>61</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>	
13. FATHER'S NAME <i>Charles Daffin</i>		14. MOTHER'S MAIDEN NAME <i>Lenora</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>George P. Northman-2607 List Ave</i>	
18. <i>17570 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Cardiac failure</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>Malnutrition & orary e</i>			
		(C) <i>Metastasis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Jan. 11, 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Good</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 11</i> 19 <i>65</i> to <i>Jan. 16</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Jan. 16</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joan Sweet Lee</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Jan. 16, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOAN SWEET LEE</i>		23D. ADDRESS <i>Lutheran Hospital of Md.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-19-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cem.</i>	
				24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc. - 6415 Belair Rd</i>	

June 24/1919

Dec 17/1919

1919

1919



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

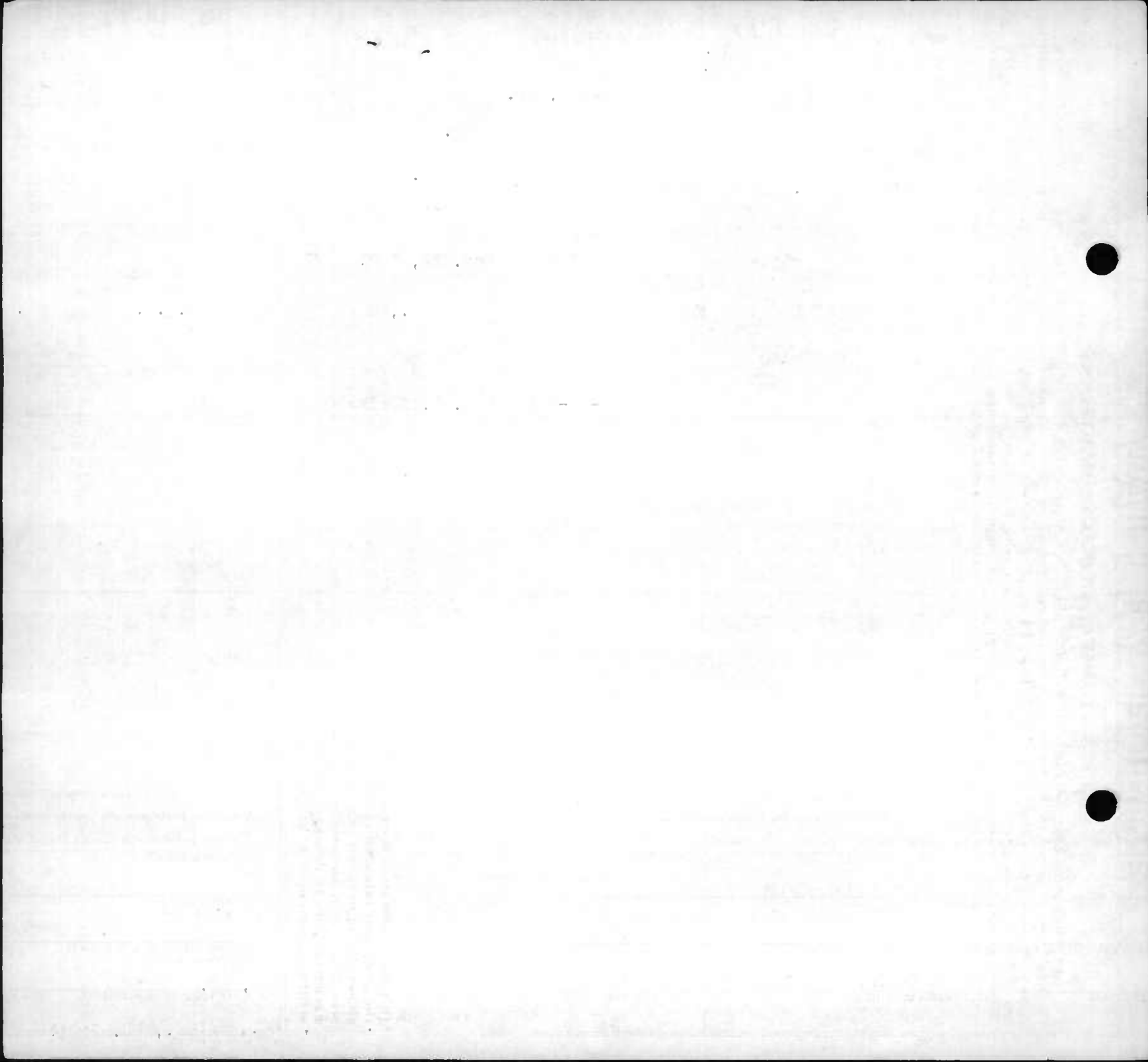
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0694	
BIRTH NO. 65 0694		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Marie C. Senft			
2. DATE AND HOUR OF DEATH January 19, 1965 4 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-01			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5400 Mayview Avenue			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH April 7, 1897	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Mangold		14. MOTHER'S MAIDEN NAME Louise F. Zimmer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-40-9282		17. INFORMANT Mr. Harold F. Senft, Sr.	
ADDRESS same					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4-20-1 I Coronary Occlusion		CAUSE OF DEATH (A) DUE TO Coronary Heart dis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-30-1962 to 1-19-1965 , that (I) was last saw the deceased alive on 1-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Coral Gordon		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) Coral Gordon		23D. ADDRESS M.D. 300 E. North Avenue Balto., Md. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-23-1965		24C. NAME OF CEMETERY or CREMATORY Gardens Of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Road # 14	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

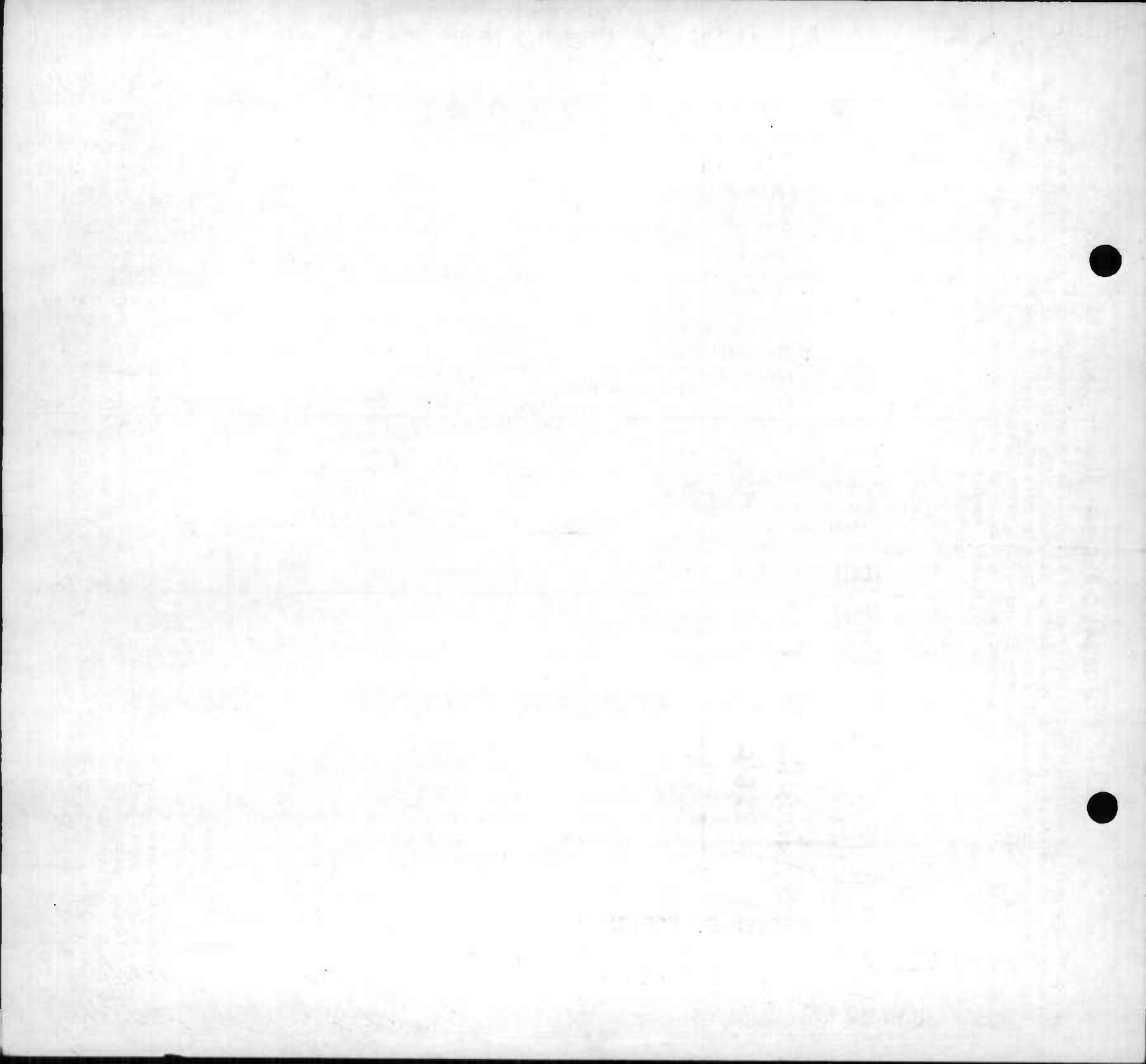
BALTIMORE CITY HEALTH DEPARTMENT									
65 0695					65 0695				
BIRTH NO.					REGISTERED NO.				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) Cusimano, Frederick, Sr.					1/19/65 5:55 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTO. GENERAL HOSPITAL					A. STATE MD.				
(If not in hospital or institution, give street address or location)					B. COUNTY 27-06				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.				
					D. STREET ADDRESS (If rural, give location) 5411 TRAMORE ROAD				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 22, 1891	9. AGE (In years last birthday) 73	11. BIRTHPLACE (State or foreign country) BALTO., MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY FRUIT		13. FATHER'S NAME JOSEPH CUSIMANO				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-32-9258		17. INFORMANT MRS. C. CUSIMANO				
					ADDRESS SAME				
18. 4.20.11 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that at (this hospital) attended the deceased from 1/19/65 to 1/19/65 , that at (we) last saw the deceased alive on 1/19/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. at (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Douglas Weir					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/65		
23C. PHYSICIAN'S NAME (Type) DR. W. Douglas Weir					23D. ADDRESS South Balto. Gen. Hosp. 1213 Light St.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC.		ADDRESS BALTO., MD. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0696 X					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 0696				
1. NAME OF DECEASED (Type or Print) DANCE, Laurence Francis					2. DATE AND HOUR OF DEATH 1.20.65 5.20A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital					A. STATE MARYLAND				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 34 53-00				
					D. STREET ADDRESS (If rural, give location) 3220 WOODSIDE AVE.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/6/81	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME SCOTT DANCE					14. MOTHER'S MAIDEN NAME LAURA JENKINS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-01-1114		17. INFORMANT MRS. GRACE DANCE		ADDRESS SAME		
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
					(A) CARCINOMA OF PROSTATE DUE TO				
					(B) SECONDARY BLEEDING FROM SAUW DUE TO				
					(C) _____				4 years approx.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					19A. DATE OF OPERATION 0 NONE				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -
					20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -				
22. I certify that (I) (this hospital) attended the deceased from 1-17-1965 to 1-20-1965 , that (I) (we) last saw the deceased alive on 1-20-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Steven E. Kopits					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1.20.65		
23C. PHYSICIAN'S NAME (Type) STEVEN E. KOPITS					23D. ADDRESS M.D. The Union Memorial Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-22-65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 5305 Hayford		



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0697					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) MR. ALFRED T. MABEN					2. DATE AND HOUR OF DEATH 1/19/65 4:12 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 27-38				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #12				
					D. STREET ADDRESS (If rural, give location) 1631 WAVERLY WAY				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 4-17-1901	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL			10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ALFRED MABEN					14. MOTHER'S MAIDEN NAME CLARE TAYLOR				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI			16. SOCIAL SECURITY NO. 067-01-1529		17. INFORMANT HOSPITAL CHART		ADDRESS BALT 31, MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Atherosclerotic Heart Disease (Probable coronary artery occlusion.) (B) DUE TO (C)				
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic peripheral vascular disease & gangrene of R foot					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 12/26/64 and 1/16/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Inadequate circulation to legs - gangrene			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from Dec. 19 1964 to Jan 16 1965 that (we) lost saw the deceased alive on Jan 16 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE James S. Gregory M.D.					23B. DATE SIGNED 1/19/65			23C. PHYSICIAN'S NAME (Type) JAMES S. GREGORY M.D.	
23D. ADDRESS Church Home + Hosp.									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/22/65		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEM.			24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.			25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC.			ADDRESS BALTO. 14 MD.	

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65 0698

BALTIMORE CITY HEALTH DEPARTMENT

65 0698

BIRTH NO. 59-27352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. SCHREVER 3rd.

2. DATE AND HOUR PRONOUNCED DEAD January 18, 1965 10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-02

D. STREET ADDRESS (If rural, give location) 2931 Eastern Avenue

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Sept. 5, 1959.

9. AGE (In years last birthday) 5

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William H. Schreven Jr.

14. MOTHER'S MAIDEN NAME Bonita Butta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS William H. Schreven Jr. 201 W. Franklin St. Balto. 1 Md.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Conflagration with fire gas inhalation

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2931 Eastern Avenue 01-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 18 65 9:55A.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Inhaled fire gas during fire in home

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John E. Adams M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1-19-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 1/21/65.

23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. JAN 20 1965

24B. NAME OF REGISTRAR Robert E. Farley, M.D.

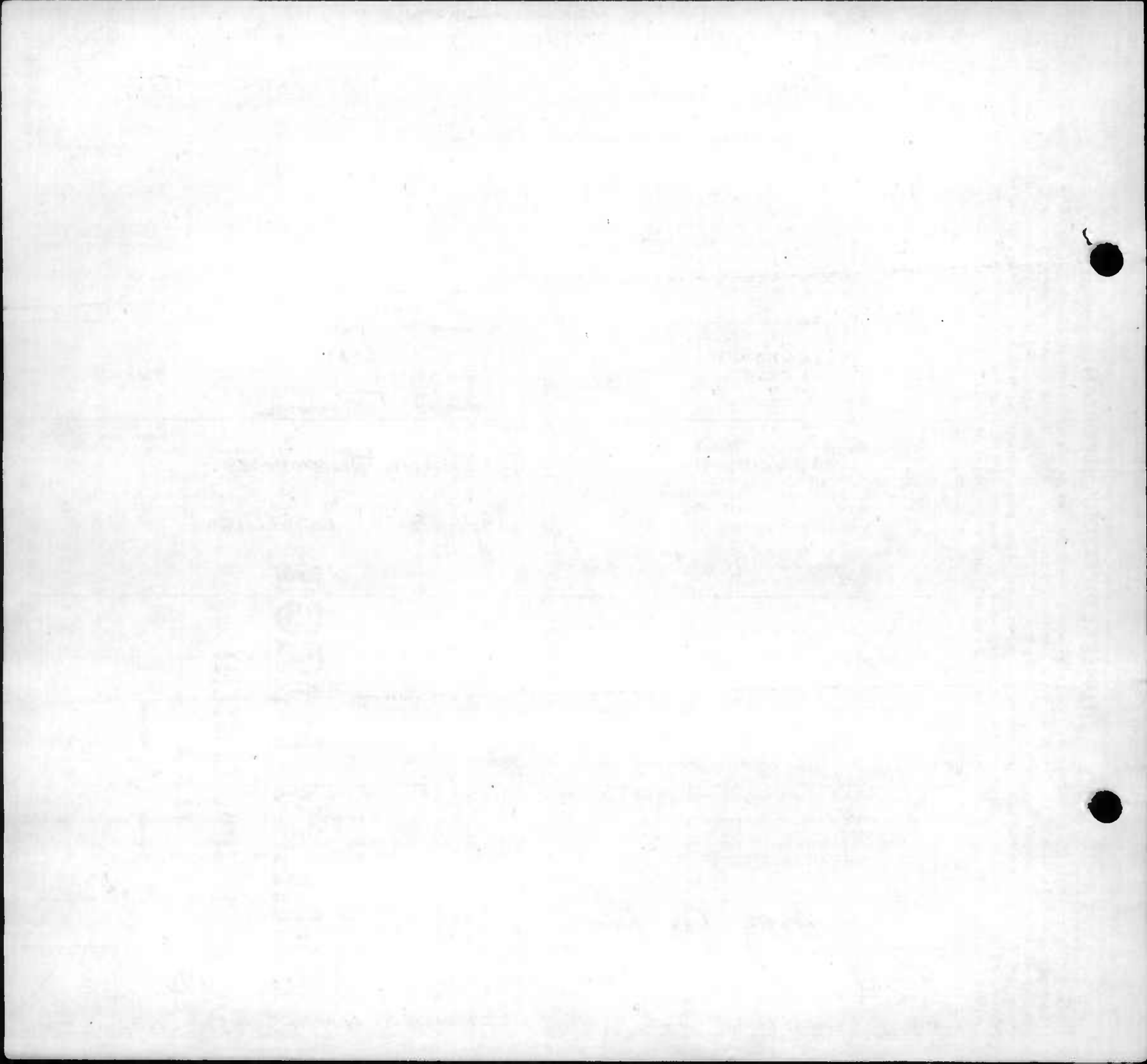
24C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14, Md.

VS 151-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

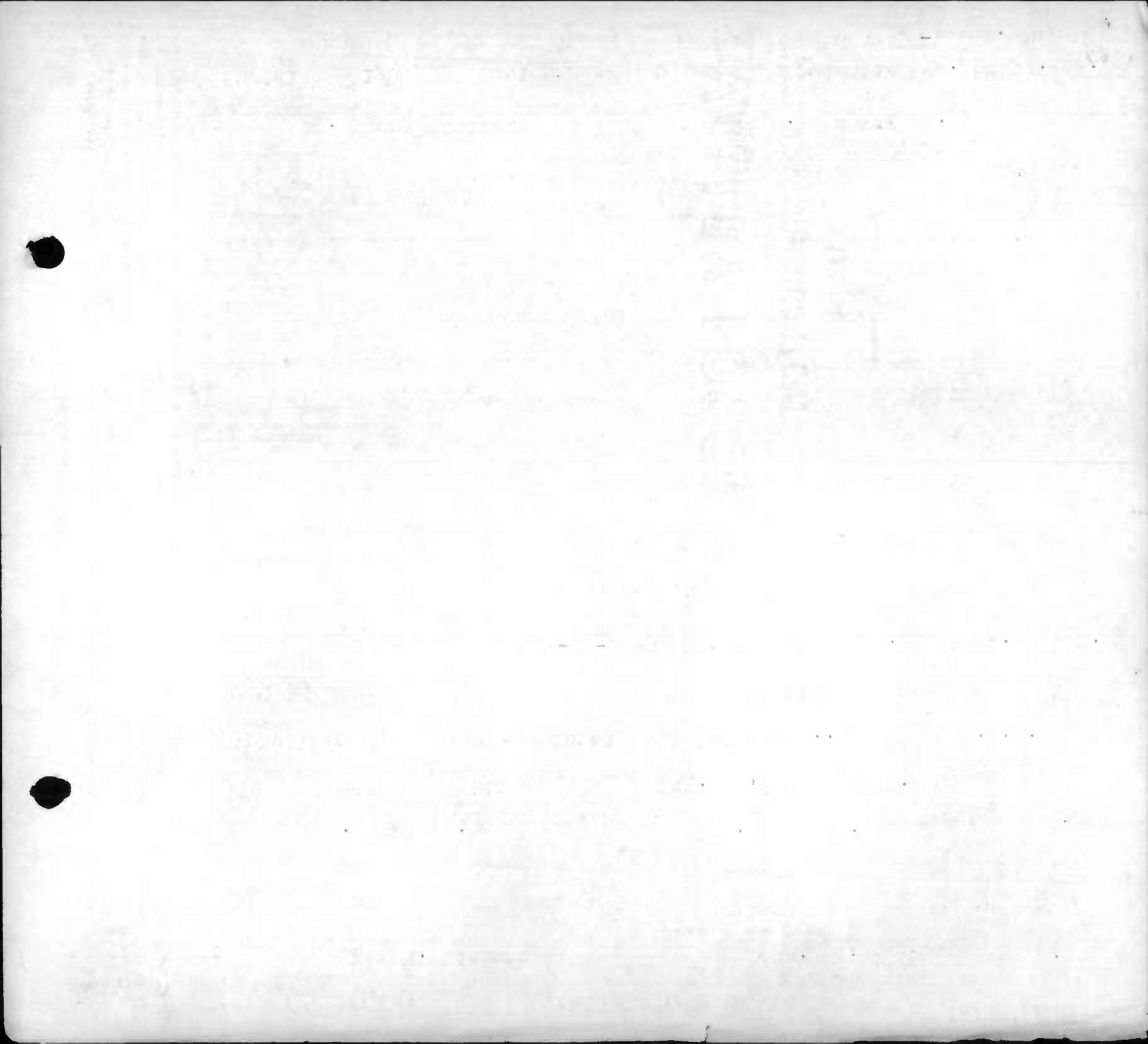
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0699</u>	
BIRTH NO. <u>65 0699</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Colvin Anna</u>		2. DATE AND HOUR OF DEATH <u>1/17/65</u> <u>1:30 AM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balts.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Franklin Square Hospital</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>6503 Green Spring Son</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH <u>3/22/1885</u>	9. AGE (In years last birthday) <u>79</u>	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Hosp. Records</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary thrombosis</u> <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/17/65</u> 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Byong Koo Kim</u> M.D.				23B. DATE SIGNED <u>1/17/65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>Franklin Square Hosp.</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>OKEB Shalom</u>	
24D. LOCATION <u>BALTO. MD</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>			
24F. NAME OF REGISTRAR <u>R. B. E. Taylor</u>		24G. FUNERAL DIRECTOR ADDRESS <u>SYLVAN S. LEWIS & Son - 3319 Olympia Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

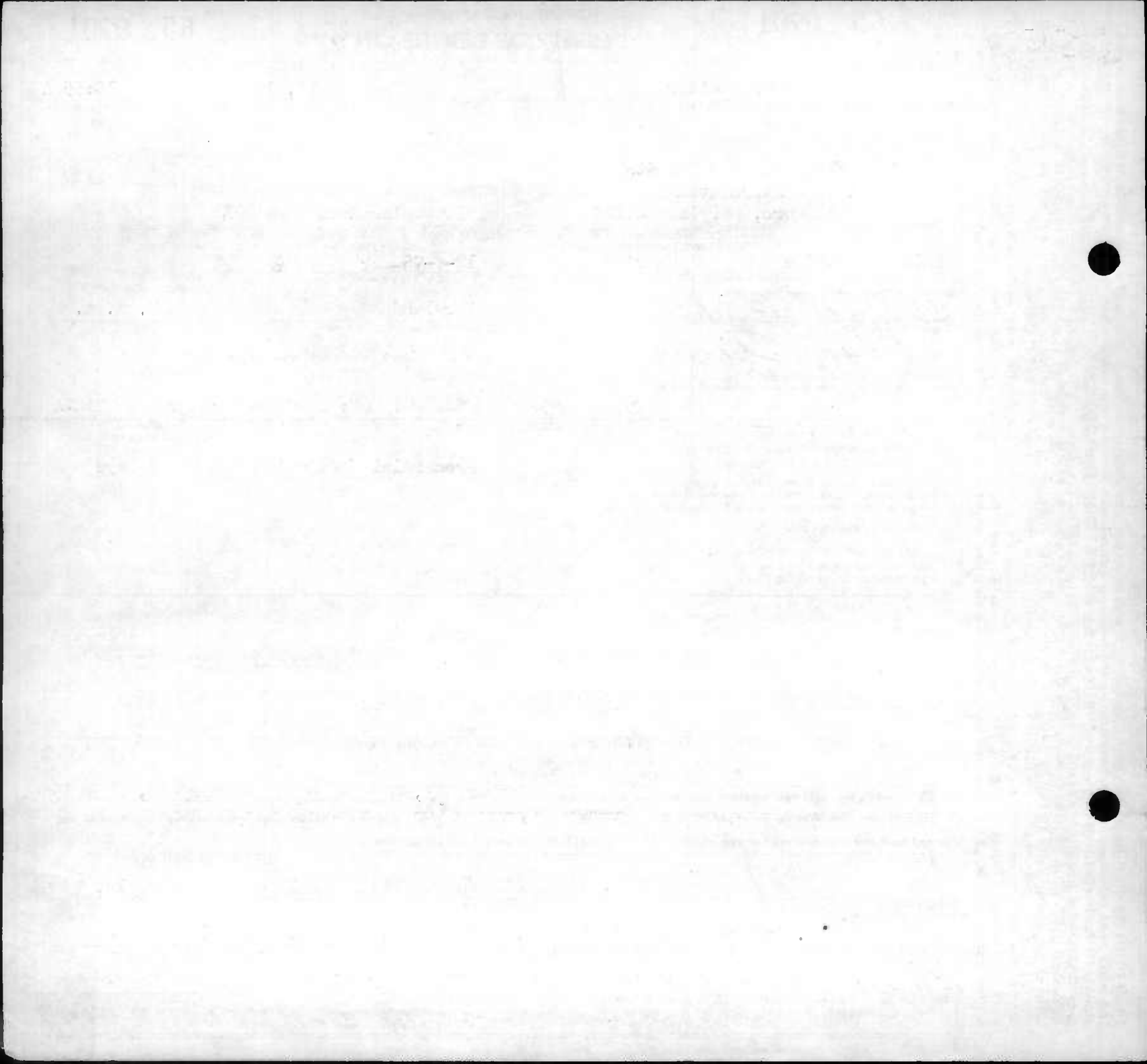
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 0700</u>	
BIRTH NO. <u>65 0700</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Max H. Niemann</u>		2. DATE AND HOUR OF DEATH <u>Jan. 19, 1965</u> <u>4 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>17 W. West St.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>23-01</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>17 W. West St.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 12, 1898</u>	9. AGE (In years last birthday) <u>66yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shipbuilder</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl Niemann</u>				14. MOTHER'S MAIDEN NAME <u>Friedericka Grenzemann</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>217-03-0693</u>		17. INFORMANT ADDRESS <u>Maxine Bell 17 W. West St. Balto.</u>			
18. CAUSE OF DEATH <u>4201 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio sclerotic heart disease</u> <u>3 years</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/13/61</u> 19 to <u>1/19/65</u> 19, that (I) (we) last saw the deceased alive on <u>1/19/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Harry Deibel</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/20/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Harry Deibel</u>				23D. ADDRESS M.D. <u>1226 S. Hanover St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Ave. Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>KRAUSE FUNERAL HOME 1216 S. Charles St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0701	
CERTIFICATE OF DEATH X					
BIRTH NO. 65 0701		1. NAME OF DECEASED (Type or Print) John Reiter			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH January 18, 1965		10:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			D. STREET ADDRESS (If rural, give location) 310 Poplar Road 21221		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-8-38	9. AGE (In years last birthday) 26	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Standard Oil-Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Adam Reiter			14. MOTHER'S MAIDEN NAME Rose Durrigan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-2283		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 5 Days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Pneumonia		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 13, 1965 to January 18, 1965 , that (I) (we) last saw the deceased alive on January 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Robert Cooke				23B. DATE SIGNED January 18, 1965	
23C. PHYSICIAN'S NAME (Type) C. Robert Cooke			23D. ADDRESS 4940 Eastern Avenue #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-64		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Connelly 300 Mace Ave. Balto. 21			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EMORY SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

January 16, 1965 10:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

173 Riverside Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 9, 1917

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Holder (Anchor Motor Freight)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Melvin F. Scott

14. MOTHER'S MAIDEN NAME

Evelyn Spinnus

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-18-6817

17. INFORMANT

Wife (Same as above)

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Strangulation
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Cell

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Essex Police Station

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1 16 65 9:40p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hung self

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-20-65

23C. NAME of CEMETERY or CREMATORY

Mt. Carmel

23D. LOCATION

Balt. Co.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Connelly 300 Mace Ave. Balt.

ADDRESS

21

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES J. SCHULTZ, SR.

2. DATE AND HOUR OF DEATH

Jan. 17, 1965

9:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

Res., 2536 Falt Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2536 Falt Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 1, 1900

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired, Brewery Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Schultz

14. MOTHER'S MAIDEN NAME

Martha Schultz

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-10-2030

17. INFORMANT

ADDRESS

Wife, Tillie Schultz, #4, a, b, c, d.

18.

14 PX I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Carcinoma of Throat

INTERVAL BETWEEN
ONSET AND DEATH

8 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A)
DUE TO

(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work

Not While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 6 19 65 to January 17 19 65,
that (I) (we) last saw the deceased alive on January 17 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Clarence W. LeDoux

M.D.

Attending
Phys.

Med.
Director

Stoff
Phys.

23B. DATE SIGNED

1/19/65

23C. PHYSICIAN'S
NAME (Type)

Clarence W. LeDoux

M.D.

23D. ADDRESS

3023 Eastern Ave. Balto. Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan-21-1965

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel

24D. LOCATION

(City, town, or county)

(State)

O'Donnell St. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

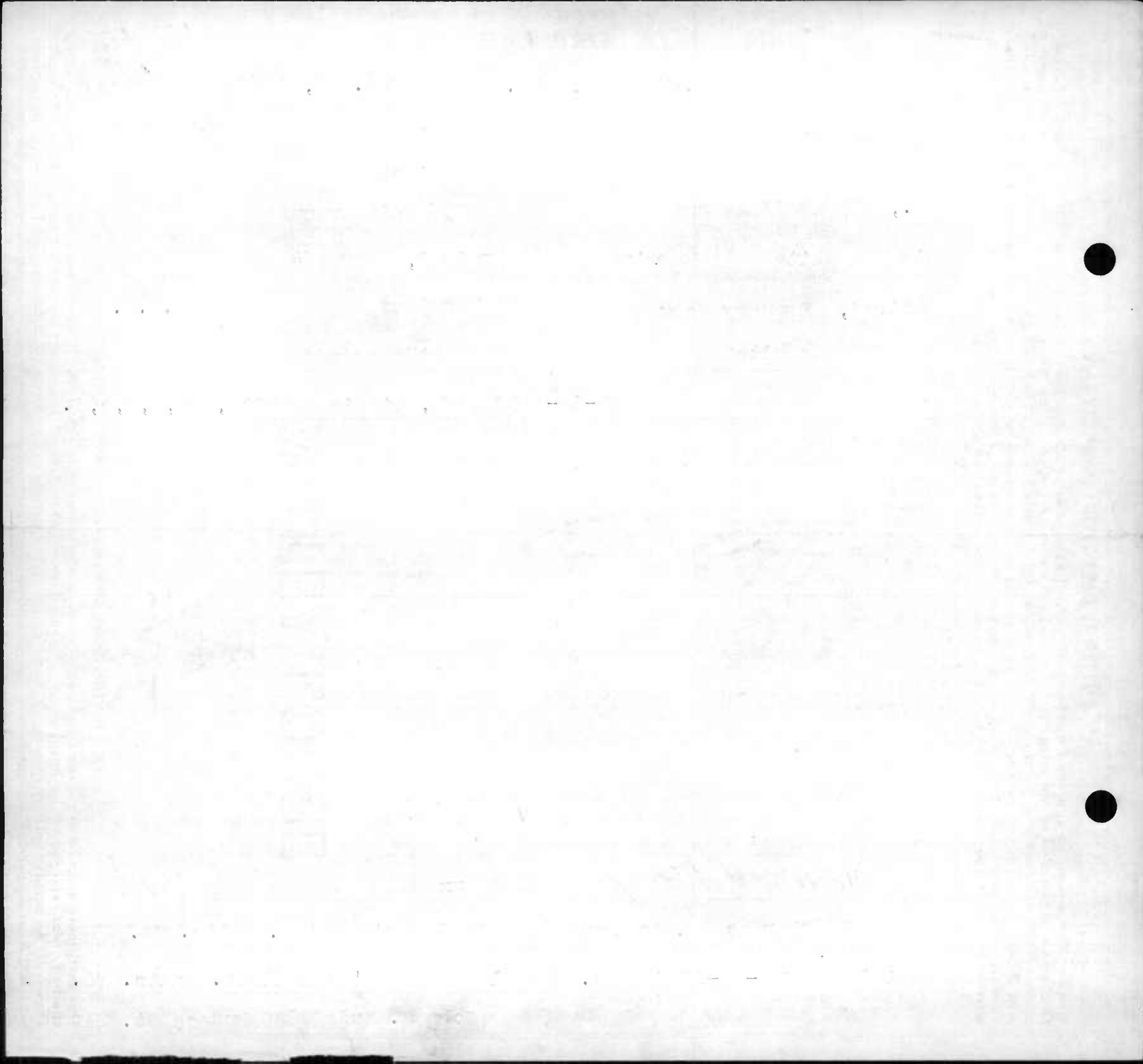
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

John J. Duda 2829 Hudson St. 21224 Md

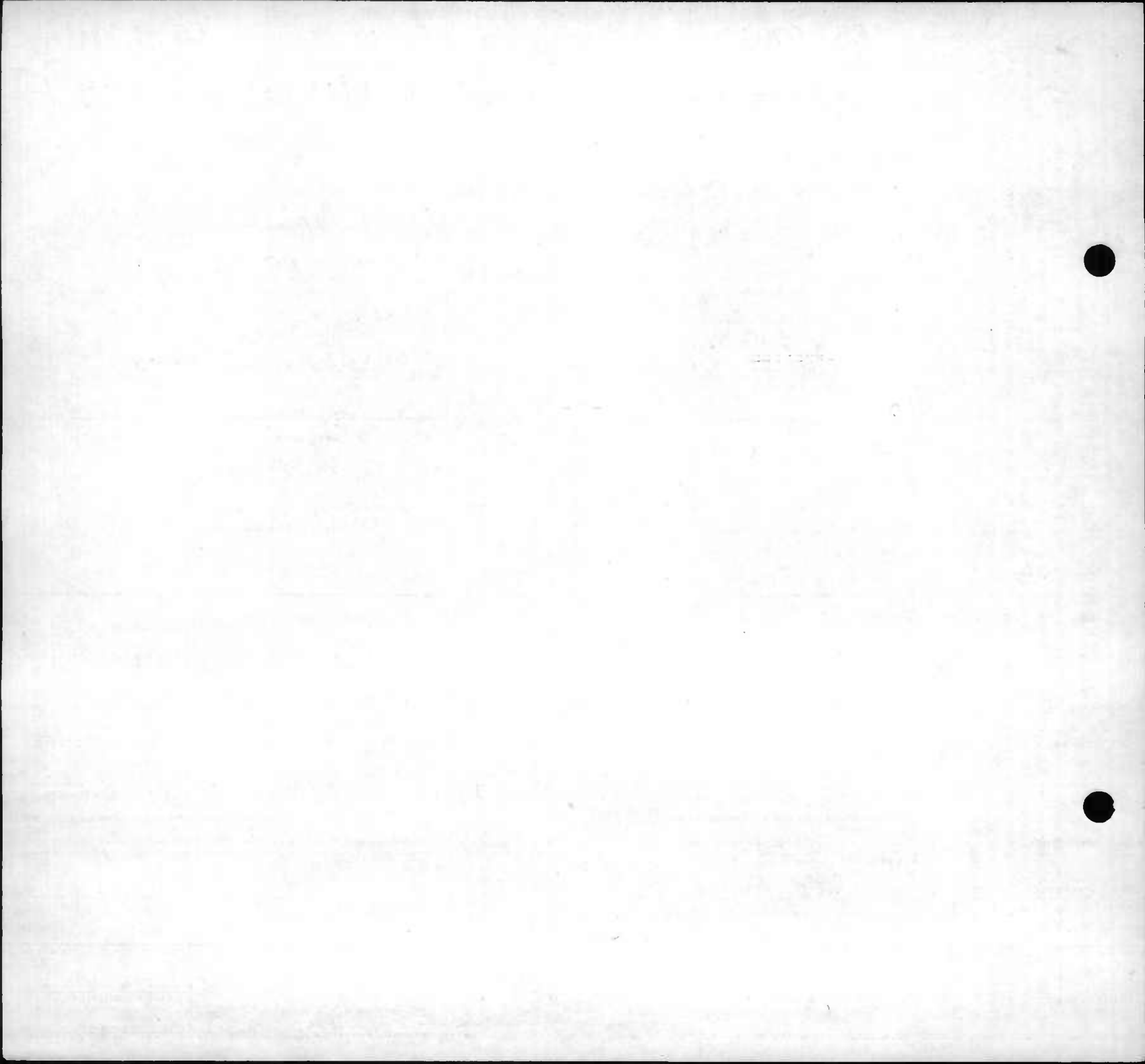
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0704	
BIRTH NO. 65 0704		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BAGNARELLI, MR. JAMES		2. DATE AND HOUR OF DEATH 1/19/65 12:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL		D. STREET ADDRESS (If rural, give location) 1127 Brentwood Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12/28/94	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10B. KIND OF BUSINESS OR INDUSTRY Water Meter Reader		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Louis P. James Bagnarelli		14. MOTHER'S MAIDEN NAME Margherita Scipioni		12. CITIZEN OF WHAT COUNTRY? US	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-8988A		17. INFORMANT ADDRESS Mande Bagnarelli Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 381.0 I		CAUSE OF DEATH (A) DUE TO Hepatic coma (B) DUE TO Liver cirrhosis (C) DUE TO Renal failure		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/4 19 65 to 1/19 19 65 , that (I) (we) last saw the deceased alive on 1/19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jojo Hyun Sohn		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19	
23C. PHYSICIAN'S NAME (Type) Jojo Hyun Sohn		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY OR CREMATORY Garden of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Seitz Funeral Home 5209 York Road Balto. Md. 21212	



B-653¹

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 65 0705

CERTIFICATE OF DEATH

BIRTH NO.

65 0705

1. NAME OF DECEASED
(Type or Print)

Lillie Bryant

2. DATE OF DEATH

January 18, 1965

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Midtown Home

808 St. Paul St.

Balt, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

BALTIMORE

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

DUNDALK

D. STREET ADDRESS

(If rural, give location)

2605 YORKWAY

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

6/25/83

9. AGE (In years
last birthday)

81

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

(If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

GLADYS HUBBARD

ADDRESS

602 MACE AVE,
ESSEX, MD.18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(A) DUE TO

Cardio-Respiratory Failure
Cerebral Hemorrhage massive

(B) DUE TO

Arteriosclerotic CHD
Gen. Arteriosclerosis

(C) DUE TO

Senility

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 5 1961 to Jan 18 1965, that (I) (we) last saw the deceased alive on Jan 18 1965 and that in (my) (our) opinion death occurred at 8:30 p.m. from the causes and on the date stated above.

23A. SIGNATURE

Attending Phys. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

23B. ADDRESS

5901 Park Heights Rd.

23C. DATE SIGNED

1/15/65

24A. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1/22/65

24C. NAME OF CEMETERY or CREMATORY

FORD HILL

24D. LOCATION

(City, town, or county)

(State)

LYNCHBURG, VA.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

25B. NAME OF REGISTRAR

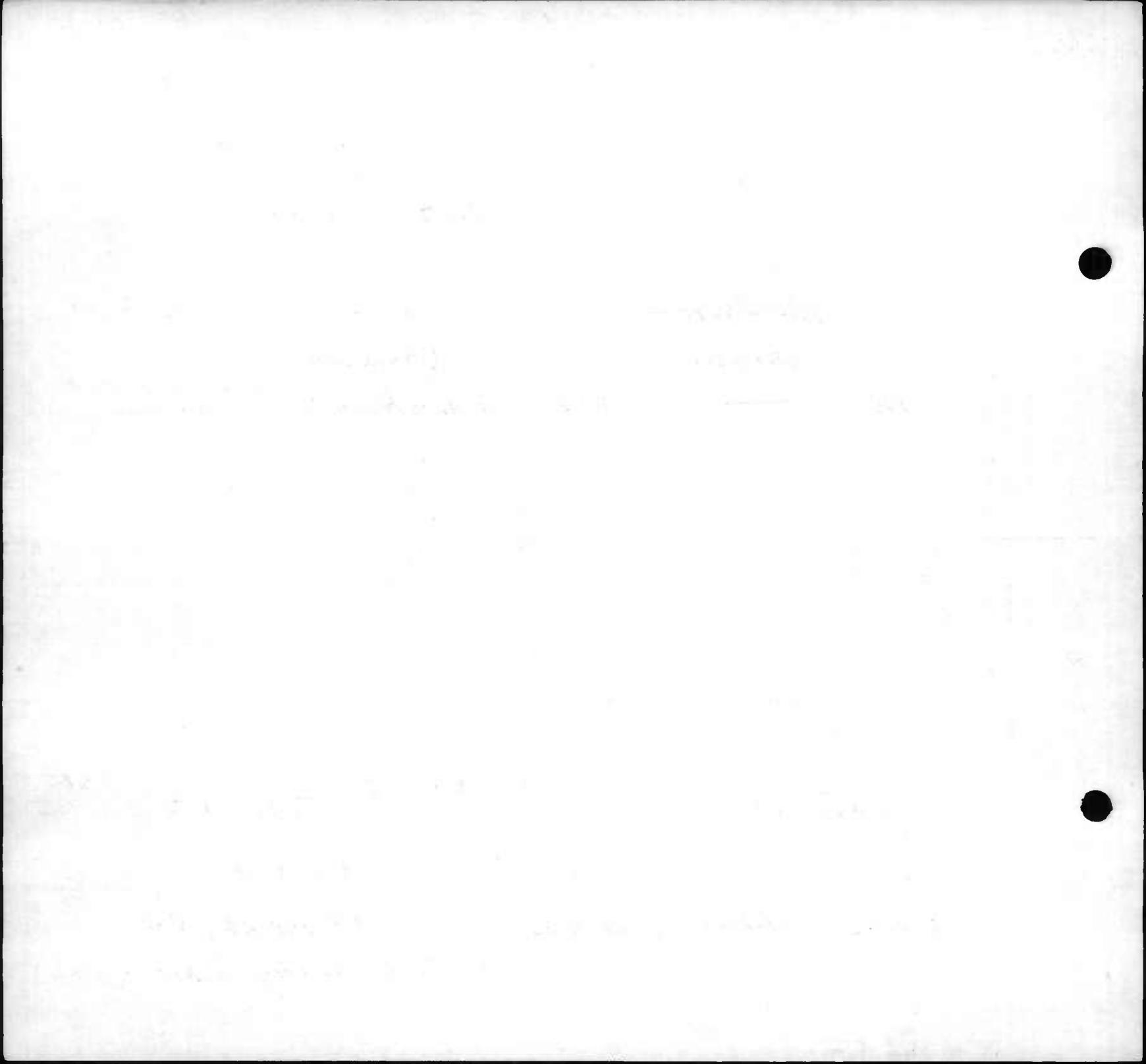
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

W. Brooke Bulley, DUNDALK, MD.

ADDRESS

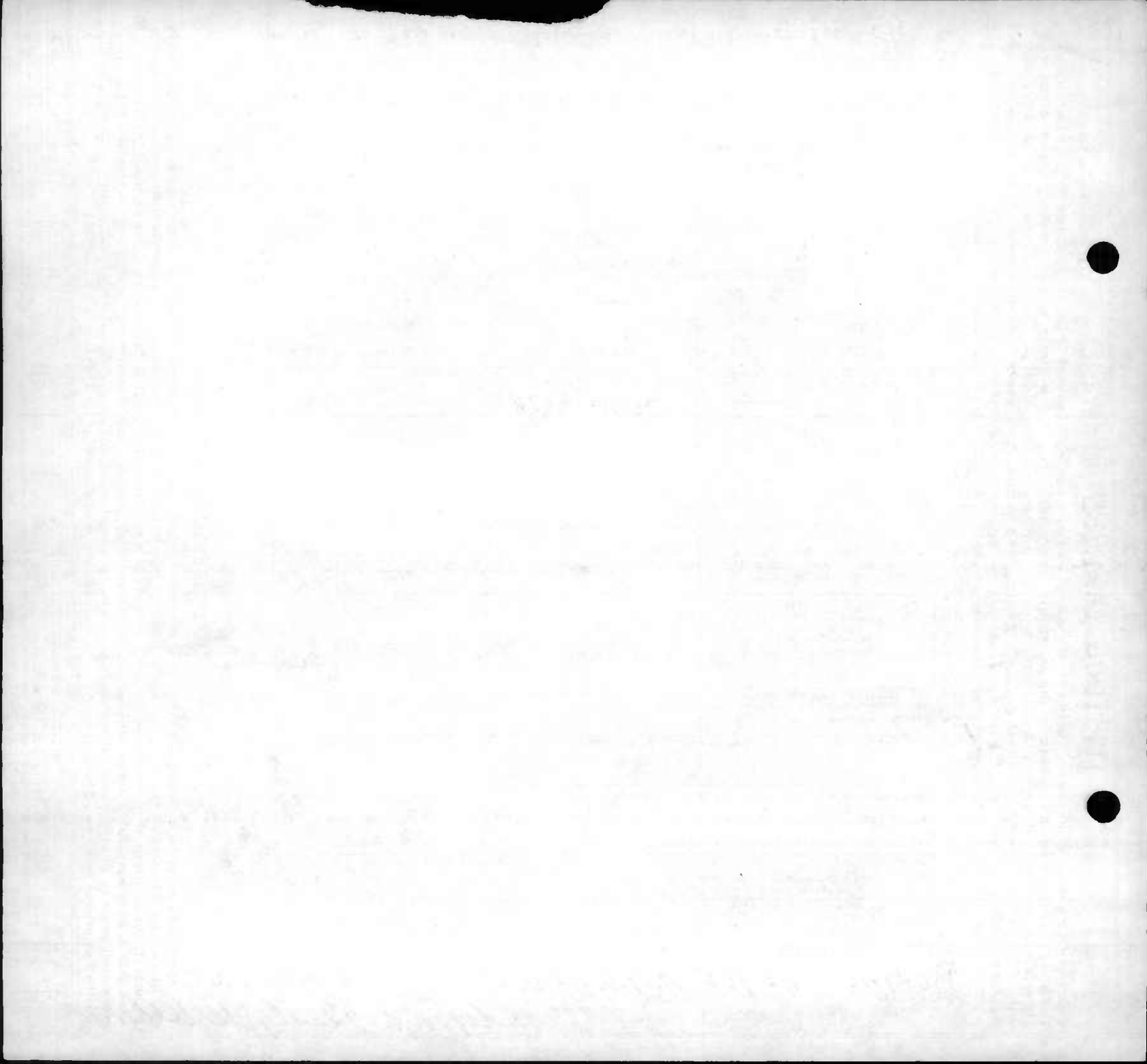
THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0706		CERTIFICATE OF DEATH		Registered No. 65 0706	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ella Virginia Hall		2. DATE AND HOUR OF DEATH 1-19-65 11:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-36	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Hospital for The Women of Md.		D. STREET ADDRESS (If rural, give location) 1311 Ballard Way			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-11-1892	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME George Henry Chaney		14. MOTHER'S MAIDEN NAME Jennie Elizabeth McKenney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 26-10-3187B		17. INFORMANT CHART	
18. 422.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cardiovascular accident,			
ANTECEDENT CAUSES		(B) DUE TO hemorrhage -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD. (Arteriosclerotic Cardiovascular disease)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-18-65 to 1-19-65 that (I) (we) lost saw the deceased alive on 11:05 AM 1-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angelita Topacio M.D.				23B. DATE SIGNED 1-19-65	
23C. PHYSICIAN'S NAME (Type) ANGELITA TOPACIO M.D.				23D. ADDRESS Women's Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/22/65		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE	
24D. LOCATION (City, town, or county) (State) DORSEY, MD		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Robert E. Fink			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0707	
BIRTH NO. 65 0707		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KATZEN DENA DENA		2. DATE AND HOUR OF DEATH JAN 20, 1965 6:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3105 LABYRINTH RD.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Aug 8, 1899	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME DAVID MOSS		14. MOTHER'S MAIDEN NAME IDA LAND		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-34-2328		17. INFORMANT MR. BERTRAM KATZEN 3105 LABYRINTH ROAD ADDRESS	
18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) G-GLIOBLASTOMA, D PARIETAL DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 11 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 12-15-64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GLIOBLASTOMA		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Dec 11 1964 to Jan 20 1965, that (1) (we) last saw the deceased alive on 20 5/8/65 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lincoln Jeanes Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan 20, 1965	
23C. PHYSICIAN'S NAME (Type) LINCOLN JEANES JR.		23D. ADDRESS M.D. Johns Hopkins Hosp. 601 N. BROADWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1/21/65	24C. NAME of CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL		24D. LOCATION (City, town, or county) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

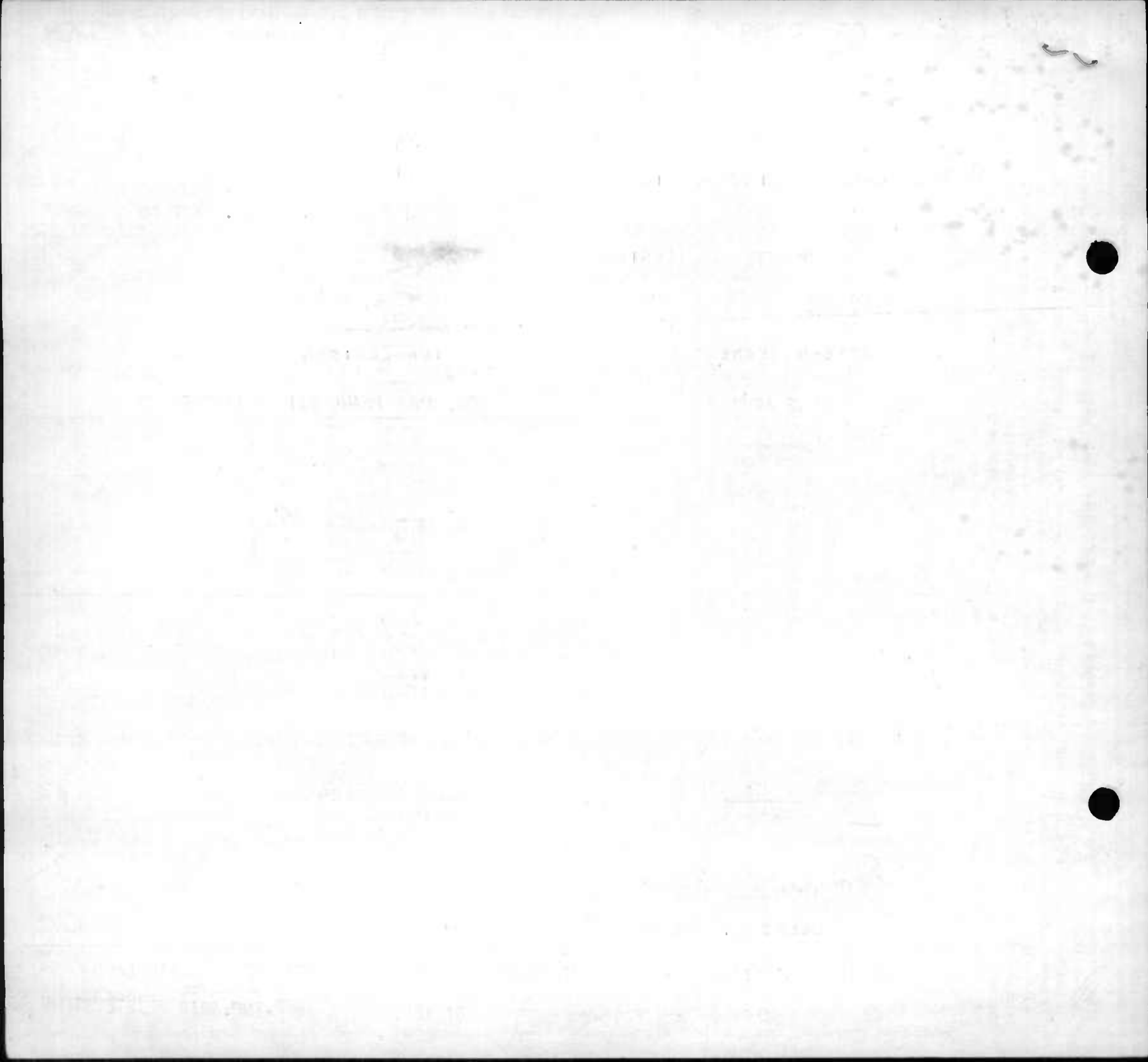
2



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

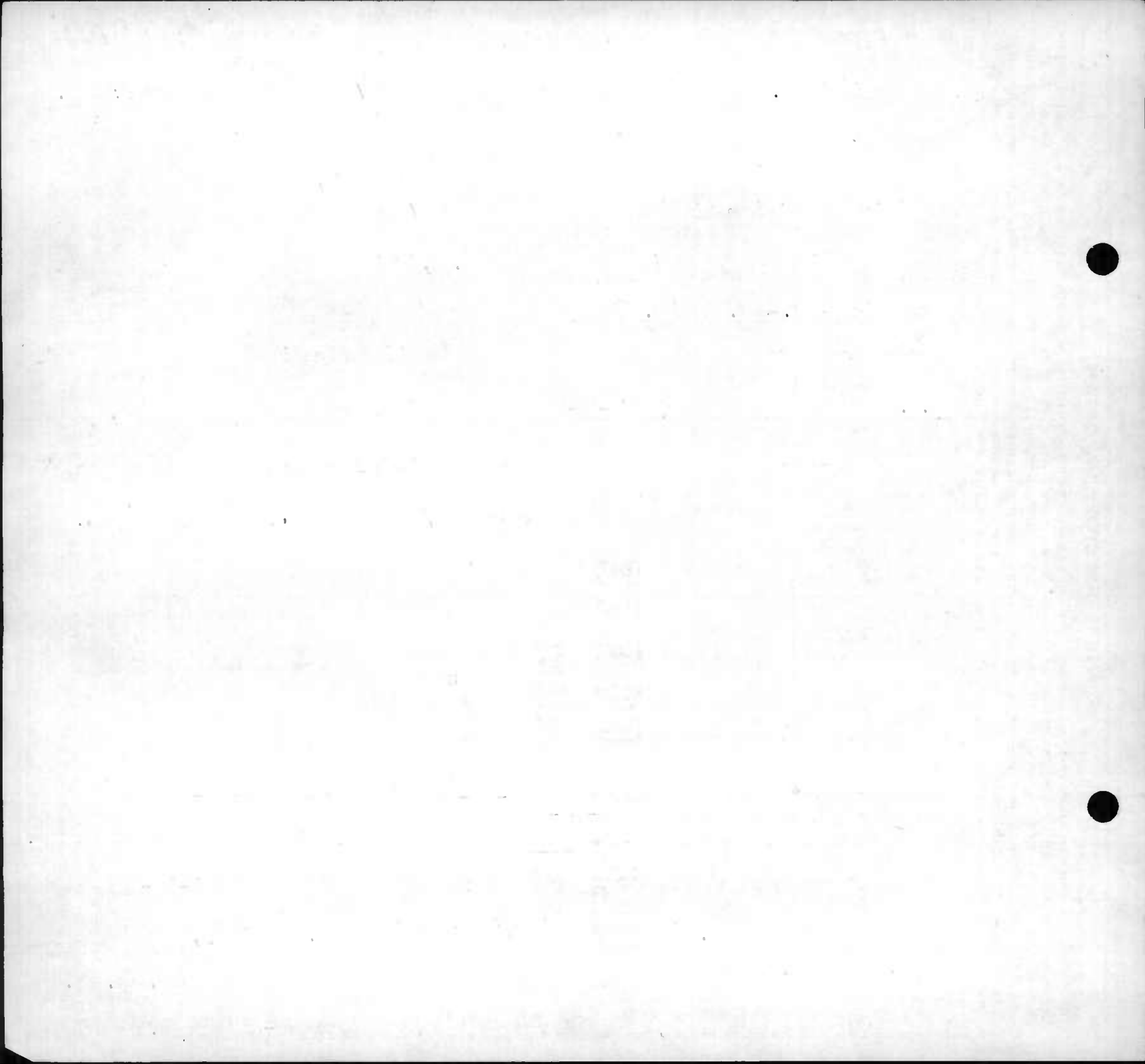
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0708</u>	
BIRTH NO. <u>65 0708</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Elliott William Deane</u>		2. DATE AND HOUR OF DEATH <u>Jan 19, 1965</u> <u>2:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>3810 FALLSTAFF RD. APT 2B</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>		11. BIRTHPLACE (State or foreign country) <u>NORFOLK, VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH DEANE</u>		14. MOTHER'S MAIDEN NAME <u>IDA ELLISON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW 2 ARMY</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. ANNE DEANE 3810 FALLSTAFF RD</u>	
18. <u>10-3-81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Carcinoma of colon with</u> DUE TO (B) <u>metastases to liver</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
19. <u>2</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congestive Heart Failure</u>		<u>1 month</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1965</u> to <u>Jan 19 1965</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Douglas W. MacRae</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Jan 19, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>DOUGLAS W. MACRAE</u>		23D. ADDRESS <u>Johns Hopkins Hosp., Balt. Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/21/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0709</u>	
BIRTH NO. <u>65 0709</u>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>William H. Myer</u>			2. DATE AND HOUR OF DEATH <u>1/14/65</u> <u>6:00 P.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>9-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 18, Maryland</u> D. STREET ADDRESS (If rural, give location) <u>3801 Greenmount Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 2, 1891</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical-eng.-ret.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Jacob Myer</u>			14. MOTHER'S MAIDEN NAME <u>Sophie May Morling</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>W.W.I</u> <u>yes</u>		16. SOCIAL SECURITY NO. <u>214-40-5500</u>		17. INFORMANT <u>Family records</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>coronary artery insufficiency 14 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-12-</u> <u>1950</u> to <u>1-14-65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-12-</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>pronounced dead Union Mem</u>					
23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D.				23B. DATE SIGNED <u>1-15-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ellsworth E. Cook</u>		23D. ADDRESS M.D. <u>2431 Maryland Ave. Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/18/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Catonsville, Balto. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>			
25B. NAME OF REGISTRAR <u>John E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>John Burns Sons 610-12 York Rd. Towson</u>			



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 0710 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0710M.E. CASE NO. 593541. NAME OF DECEASED
(Type or Print)JAMES HIGGINS (*James R. Higgins*)

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965

4:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7312 Manchester Road #22

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 27, 1907

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Crown, Conk + Seal

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James R. Higgins

14. MOTHER'S MAIDEN NAME

Goldie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-01-0361

17. INFORMANT

Margaret G. Higgins

ADDRESS

7312 Manchester Rd. #22

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-21-65

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

7225 Eastern Blvd. Balto. 24, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Charles S. Geiler, Baltimore 24, Md.

ADDRESS

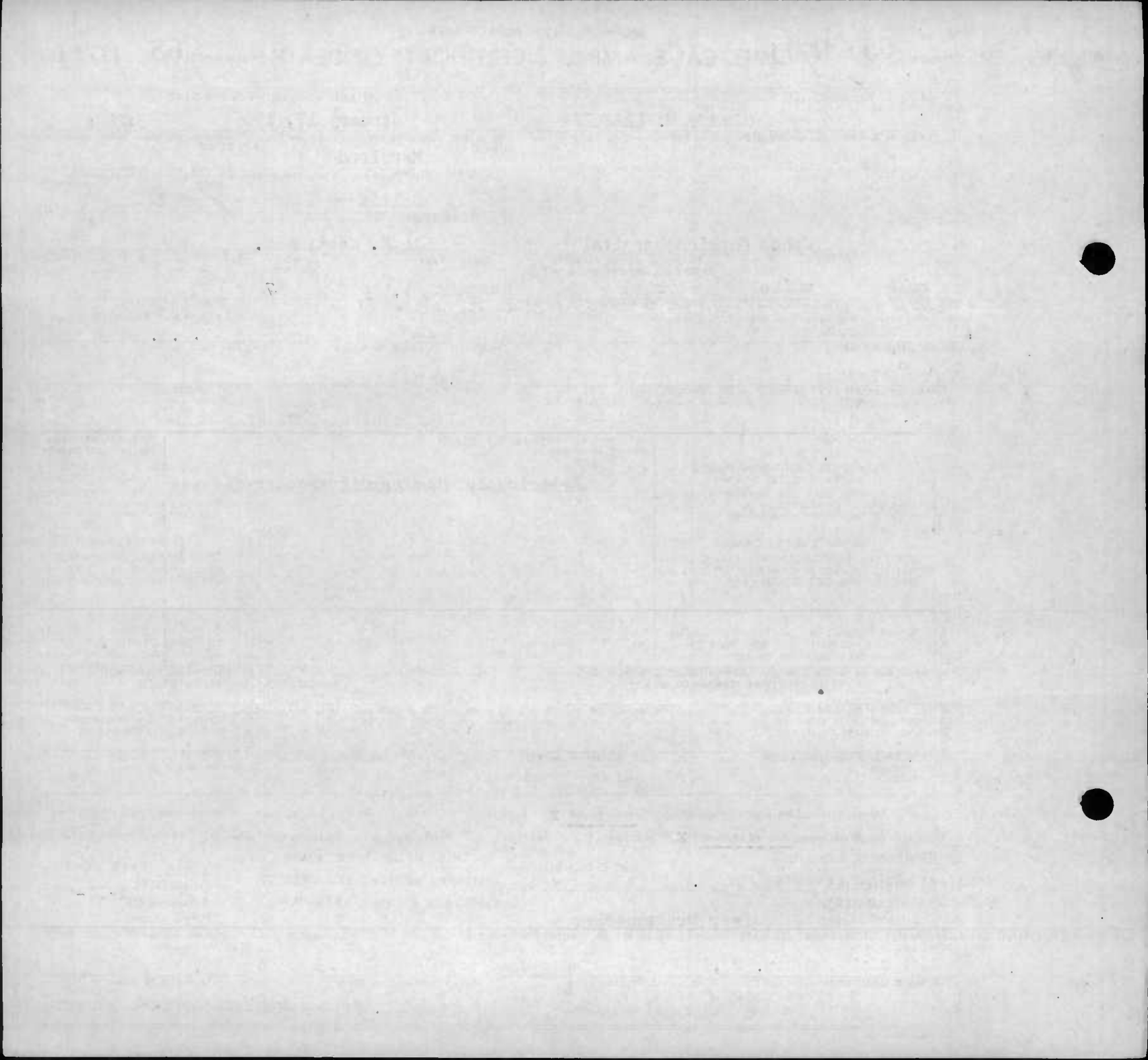
WALTER FORGE

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 0711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0711
M.E. CASE NO. 59339

1. NAME OF DECEASED (Type or Print) WALLACE W. LASZCZAK				2. DATE AND HOUR PRONOUNCED DEAD January 17, 1965 3:20 a M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-05			
D. STREET ADDRESS (If rural, give location) 514 N. Castle St.							
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH August 21, 1907		9. AGE (In years last birthday) 57	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Laszczak			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 216-09-4693		17. INFORMANT ADDRESS Rosalie Schultz 2003 Oakington Road		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Rudiger Breiteneker</i> M.D. EXAMINER'S NAME (Type) Rudiger Breiteneker DATE SIGNED 1-17-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Jan. 20, 1965		23C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore county, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		24B. NAME OF REGISTRAR Robert E. Farley M.D.		24C. FUNERAL DIRECTOR ADDRESS Raymond L. Kaczorowski 2525 Fleet Street			



BIRTH NO.

65 0712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 0712

M.E. CASE NO.

59353

1. NAME OF DECEASED
(Type or Print)

JAMES P. O'CONNOR

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965 5:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3106 Ellerslie Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 14, 1890

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fire Fighter

10B. KIND OF BUSINESS OR INDUSTRY

Balto City (retire)

11. BIRTHPLACE (State or foreign country)

Queens Co Ireland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael O'Connor

14. MOTHER'S MAIDEN NAME

Anne Delaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-28-2161

17. INFORMANT

ADDRESS

Catherine A O'Connor 3106 Ellerslie

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/22/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

J. Melville Jenkins 2713 Kirk Ave

WALTER J. CONNOR

WALTER J. CONNOR, JR.

WALTER J. CONNOR

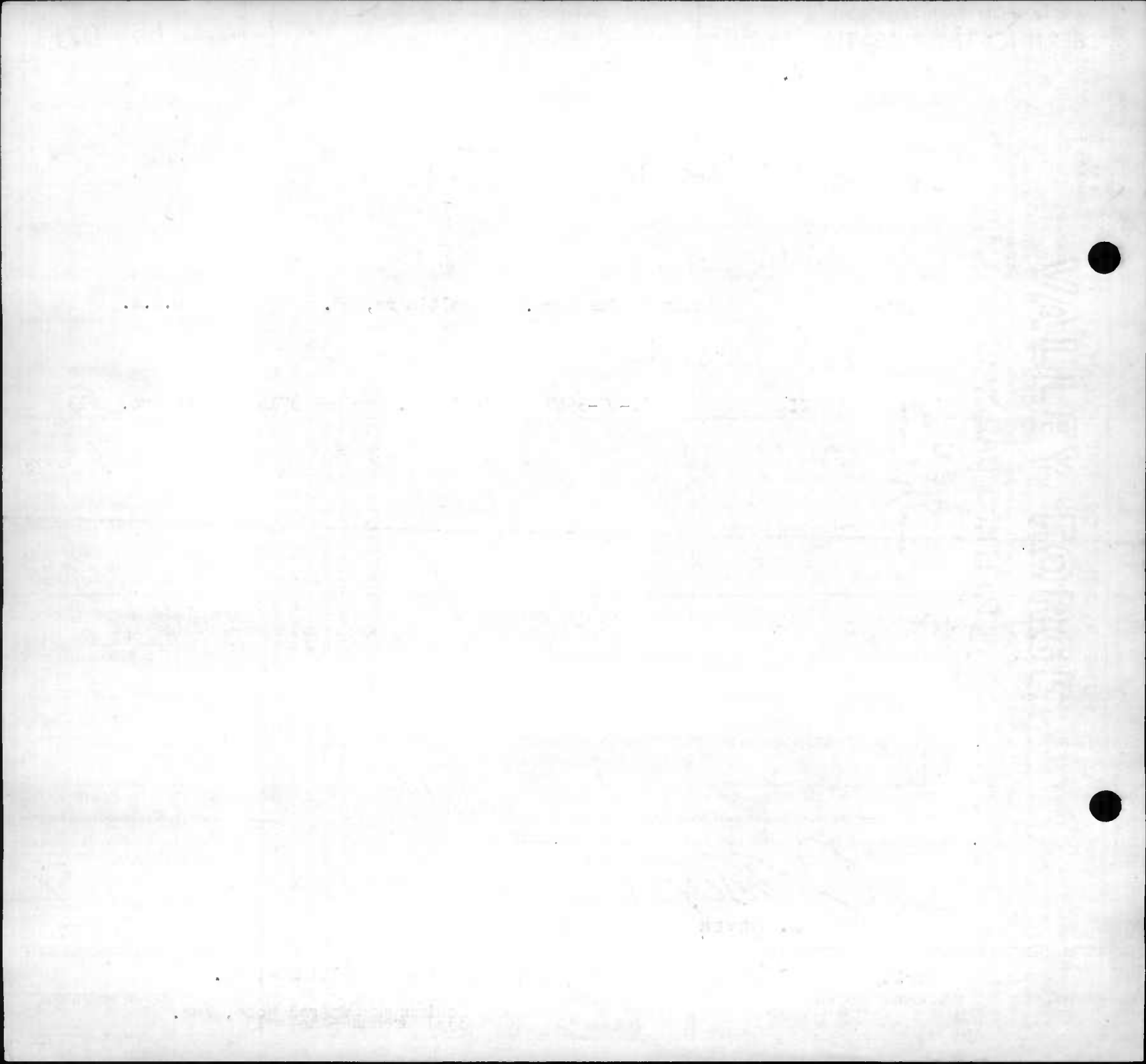
WALTER J. CONNOR

10703821

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

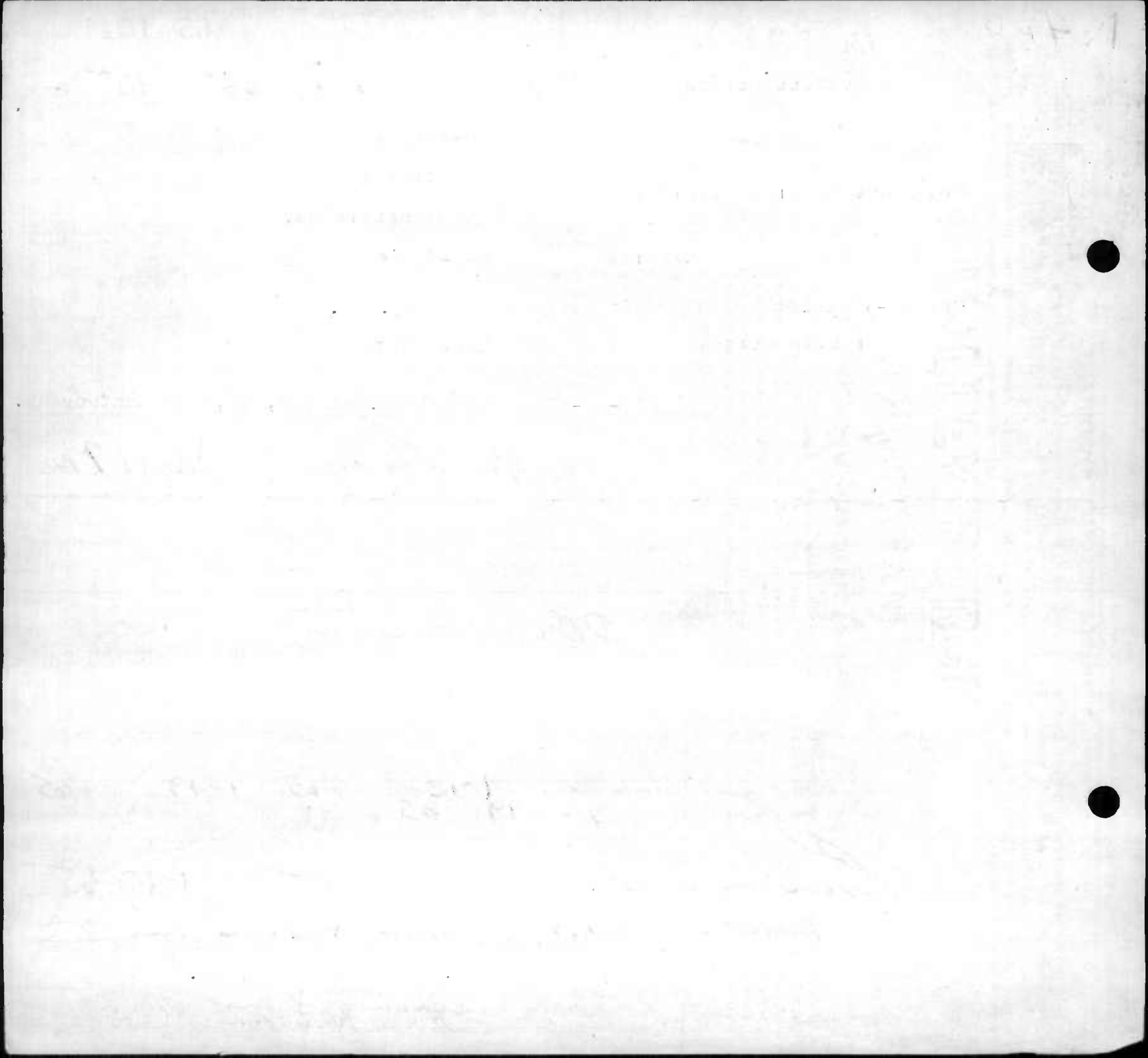
BIRTH NO. 65 0713				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0713	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Charles Beranek</i>		2. DATE AND HOUR OF DEATH <i>1/20/65</i> <i>12⁰⁵A</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-03</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 13</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>				D. STREET ADDRESS (If rural, give location) <i>3714 Bonview Ave #13</i>					
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>7/8/12</i>		9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Spouter</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Louis Dryfus Corp.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles Beranek</i>				14. MOTHER'S MAIDEN NAME <i>Mary Boz</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WWII</i>				16. SOCIAL SECURITY NO. <i>216-07-3547</i>		17. INFORMANT ADDRESS <i>Louise A. Beranek 3714 Bonview Ave. #13</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>Craniovertebral dislocation</i> <i>liver</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Electrolyte imbalance; inappropriate ADH</i>									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>1/15/65</i> 19 to <i>1/20/65</i> 19, that (I) last saw the deceased alive on <i>1/20/65 1205 AM</i> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.									
23A. SIGNATURE <i>J. Meyer</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/20/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. MEYER</i>				23D. ADDRESS <i>530 A. N. BOND BALTO.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/23/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bohemian National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Schimmek Funeral Home, Inc.</i>		ADDRESS <i>3331 Brehms Lane #13</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0714	
BIRTH NO. 65 0714		M.E. CASE NO. 65 0714		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) K. RUSSELL KLAGES			2. DATE AND HOUR OF DEATH 1-19-65 10 ⁴³ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13 D. STREET ADDRESS (If rural, give location) 3537 BELAIR RD.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-3-12	9. AGE (In years last birthday) 52	10. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver-Salesman		10B. KIND OF BUSINESS OR INDUSTRY Sinclair Refining		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME WILLIAM KLAGES			14. MOTHER'S MAIDEN NAME LAURA SETH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-4768	17. INFORMANT Russell R. Klages, son, 3502 Kentucky Av.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO possible myocardial infarction 1-2 hrs (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diffuse vasculitis					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-13-1965 to 1-19-1965, that (I) (we) last saw the deceased alive on 1-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Lee Evans				23B. DATE SIGNED 1-19-65	
23C. PHYSICIAN'S NAME (Type) BRUCE LEE EVANS		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schmied 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
CERTIFICATE OF DEATH					Registered No. 65 0715										
BIRTH NO. 65 0715		M.E. CASE NO. 65 0715			1. NAME OF DECEASED (Type or Print) XXXXXXXXXX IDA E. GNAU					2. DATE AND HOUR OF DEATH 1-19-65 3 a.m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY 603					C. CITY OR TOWN (If outside city limits, write RURAL and give township) N. Broadway and Fayette					
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital					D. STREET ADDRESS (If rural, give location) 209 N. Collington Ave.										
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed.		8. DATE OF BIRTH 1888 4-18-94		9. AGE (In years last birthday) 76		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY at home					11. BIRTHPLACE (State or foreign country) Baltimore, Md.					
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME James Marshall					14. MOTHER'S MAIDEN NAME Margaret Ripke					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS Margaret McGreeny 4415 Finlay Rd. Balt.					
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH (A) Cardiac embolus Short hours				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) Myocardial infarction? hours.					
										(C) Hypertensive heart disease years.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypothyroidism.															
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?										
22. I certify that (I) (this hospital) attended the deceased from 1-18-1965 to 1-19-1965, that (I) (we) last saw the deceased alive on 1-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE John J. Conroy										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/19/65		
23C. PHYSICIAN'S NAME (Type) John J. Conroy					23D. ADDRESS Church Home & Hospital										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery			24D. LOCATION (City, town, or county) Baltimore, Md.			(State)					
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street #5			ADDRESS							

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 0715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0716

M.E. CASE NO. 59366

1. NAME OF DECEASED (Type or Print) **THOMAS BOSTLER** 2. DATE AND HOUR PRONOUNCED DEAD **January 19, 1965** **5:00 A** M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **JOHNS HOPKINS HOSPITAL** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** **7-01**

D. STREET ADDRESS (If rural, give location) **2929 McElderry Street #5**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) **Married** 8. DATE OF BIRTH **March 7, 1900** 9. AGE (In years last birthday) **64** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Foreman** 10B. KIND OF BUSINESS OR INDUSTRY **American Sugar** 11. BIRTHPLACE (State or foreign country) **New York City** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Charles Bostler** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **16. SOCIAL SECURITY NO. 212-09-6025** 17. INFORMANT **Anna Bostler** ADDRESS **2929 McElderry Street #5**

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH (A) **Thoracic and abdominal sepsis** DUE TO (B) **Multiple traumatic injuries** DUE TO (C)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2 12-5-64** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **Fractures** 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Street** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Corner of Monument St. & Linwood Ave.** **7-01**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **12 5 64 10:35 P** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Pedestrian struck by auto**

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **John E. Adams** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **1-19-65**

EXAMINER'S NAME (Type) **John E. Adams, M.D.**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **1/22/65** 23C. NAME OF CEMETERY OR CREMATORY **Holy Redeemer Cemetery** 23D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

24A. DATE REC'D BY HEALTH DEPT. **JAN 21 1965** 24B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 24C. FUNERAL DIRECTOR **Schimunek Funeral Home, Inc.** ADDRESS **2601-03-05 E. Madison Street #5**

VS 151-REV. 1/1/65

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DATE: 10/10/70
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SUBJECT: [illegible]
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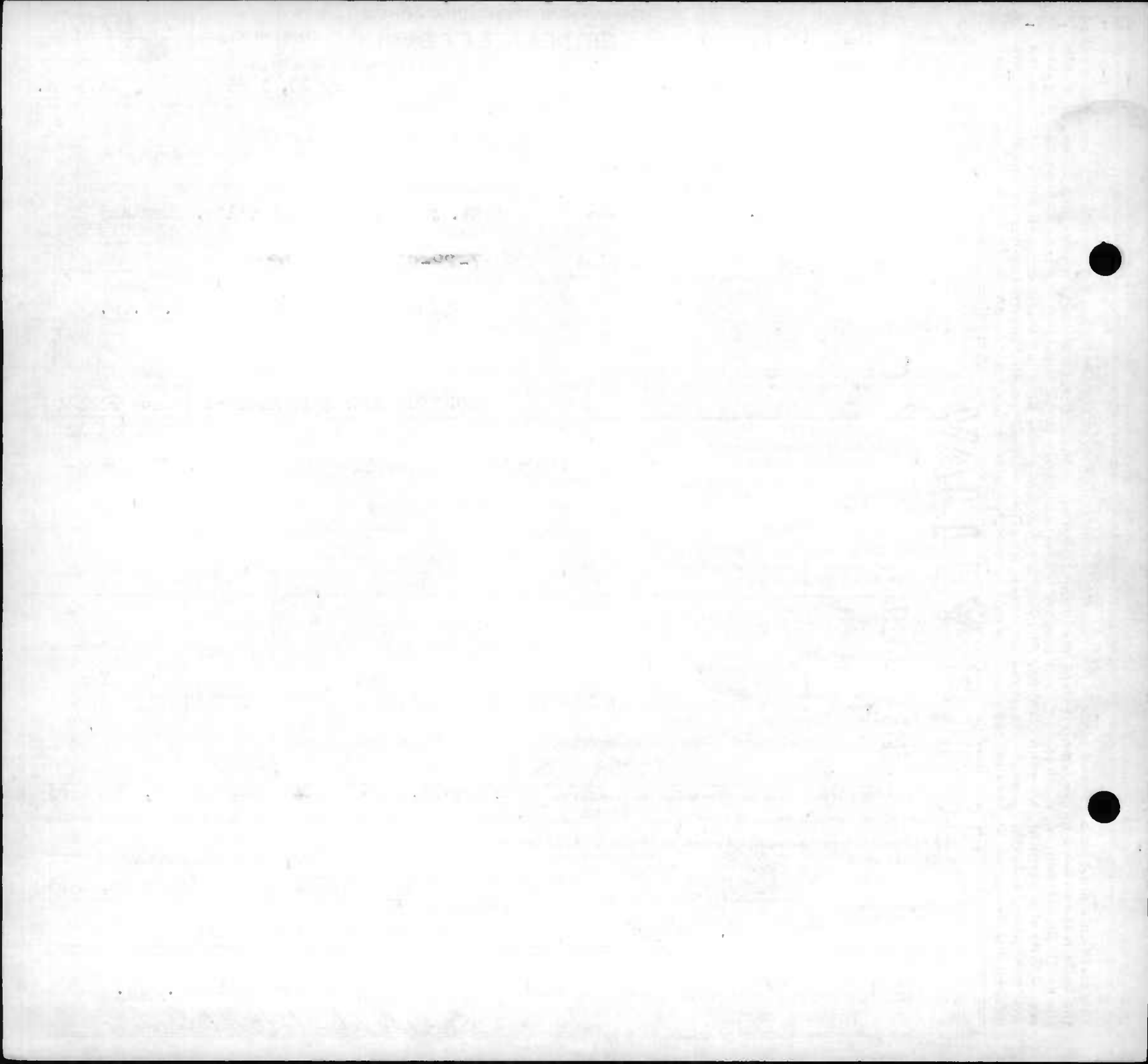
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

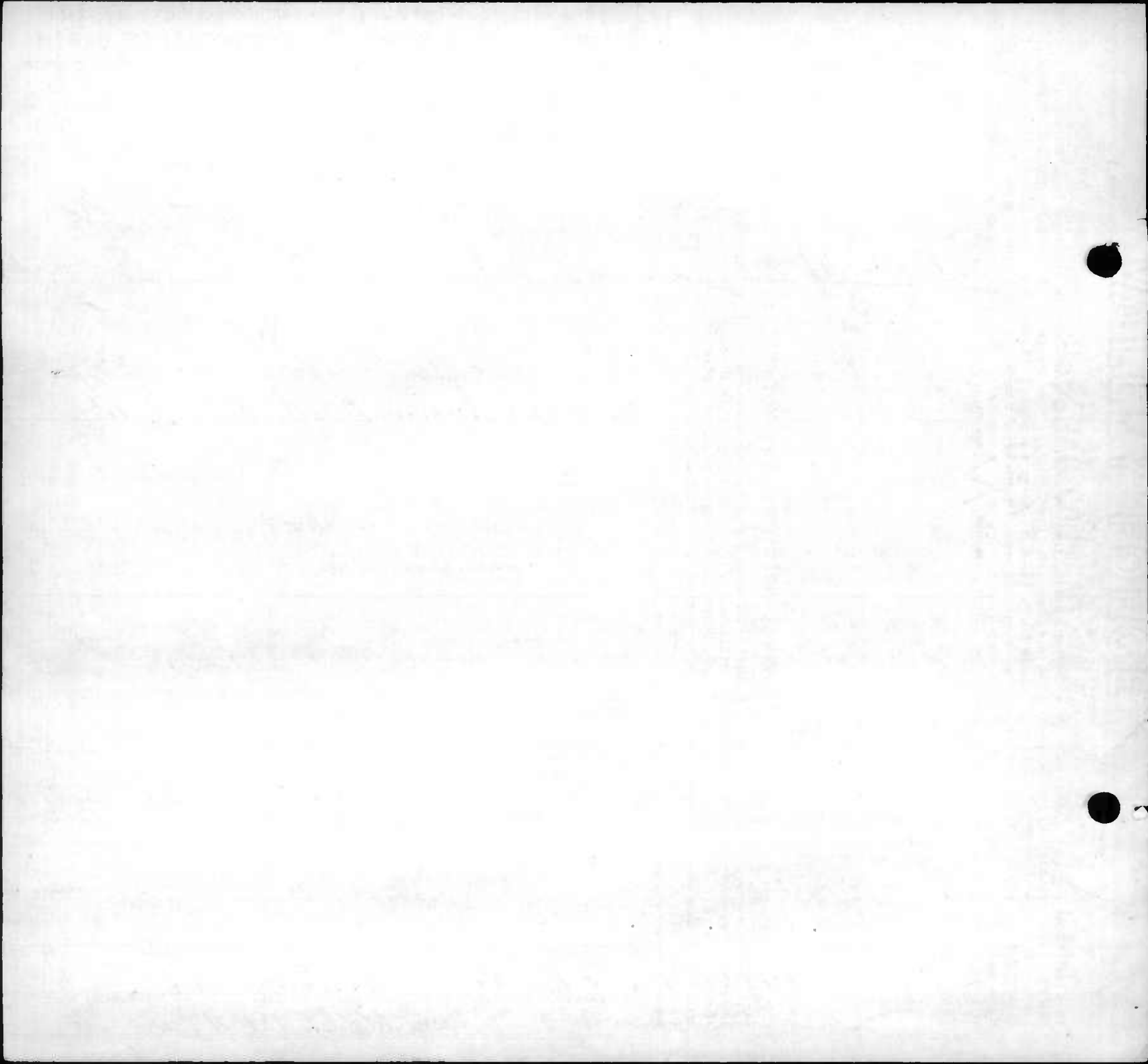
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0717	
BIRTH NO. 65 0717		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elizabeth Neal		2. DATE AND HOUR OF DEATH January 20, 1965 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY Anne Arundel			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL 52-00			
		D. STREET ADDRESS (If rural, give location) Rt. #2 Box 77 Millersville, Maryland			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-22-01	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Carcinoma of Cervix with Metastases 9 1/2 Years DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 28, 19 64 to January 20, 19 65, that (I) (we) last saw the deceased alive on January 20, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard K. Rathbun		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 20, 1965	
23C. PHYSICIAN'S NAME (Type) Howard K. Rathbun		23D. ADDRESS M.D. 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Chew Chapel	
24D. LOCATION Anne Arundel Co. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS George A. Palmer 1348 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0718				65 0718		CERTIFICATE OF DEATH		Registered No. _____	
1. NAME OF DECEASED (Type or Print) JAMES W. POWELL				2. DATE AND HOUR OF DEATH 1-20-65 5 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17 D. STREET ADDRESS (If rural, give location) 1417-N. Fulton Ave.					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-11-31		9. AGE (In years last birthday) 33	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboer		11. BIRTHPLACE (State or foreign country) M.C.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Powell				14. MOTHER'S MAIDEN NAME Emely Humbery					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2				16. SOCIAL SECURITY NO. 238-44-8313		17. INFORMANT ADDRESS Virginia Powell Kettrell, D.C.			
18. 441X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE				CAUSE OF DEATH (A) LEUREMIA DUE TO (B) HYPERTENSIVE RENAL DIS. DUE TO (C) MALIGNANT HYPERTENSION				INTERVAL BETWEEN ONSET AND DEATH 1 WK. 2 MTHS. 2 MTHS.	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from DEC 19 1964 to JAN 20 1965 , that (I) (we) last saw the deceased alive on JAN 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul D. Hart						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) DR. PAUL D. HART.						23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-64		24C. NAME OF CEMETERY or CREMATORY Louely Hill Cem		24D. LOCATION (City, town, or county) (State) Warrenton N.C.			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George H. Nelson				ADDRESS 1348 N. Calhoun St	



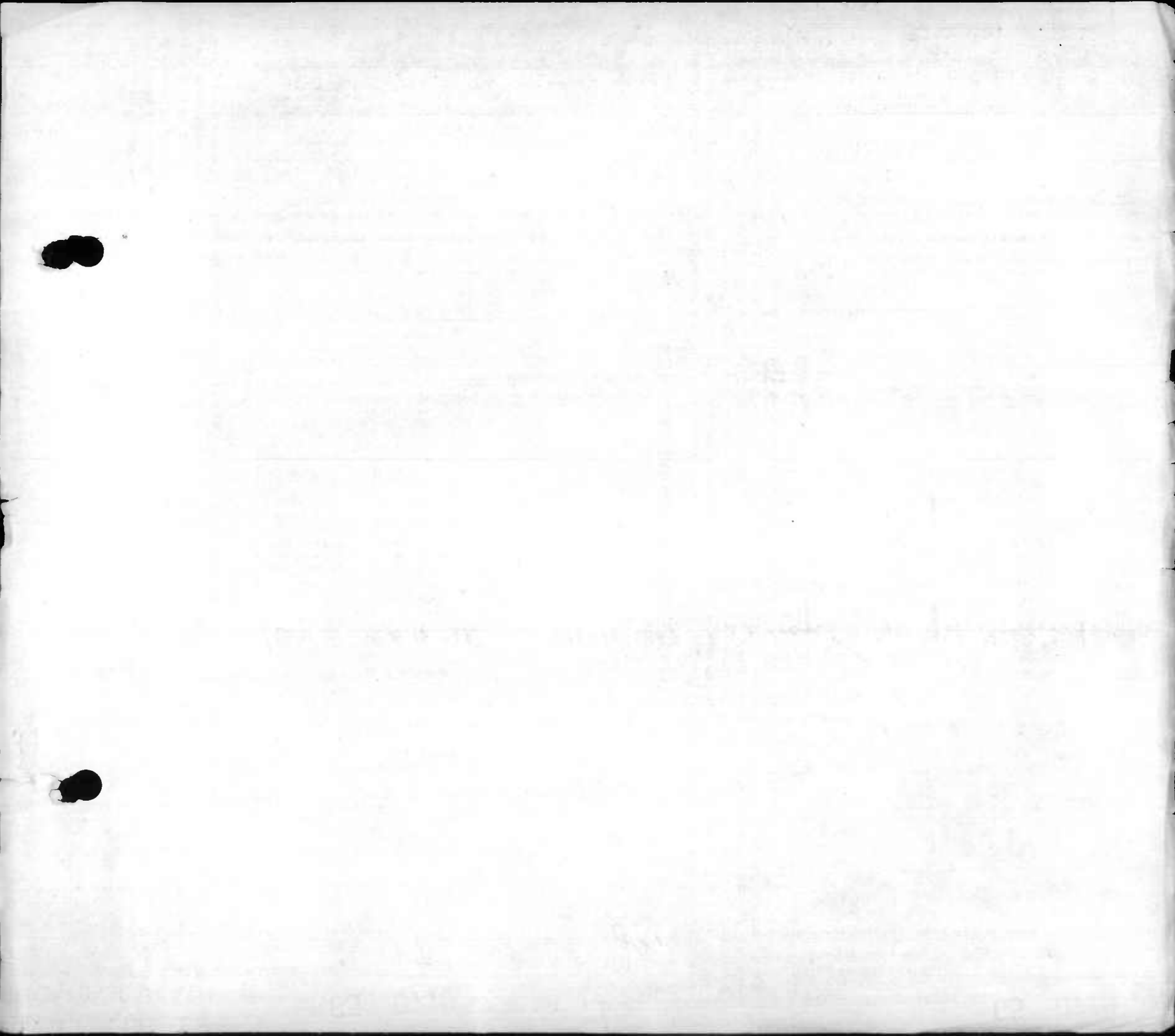
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

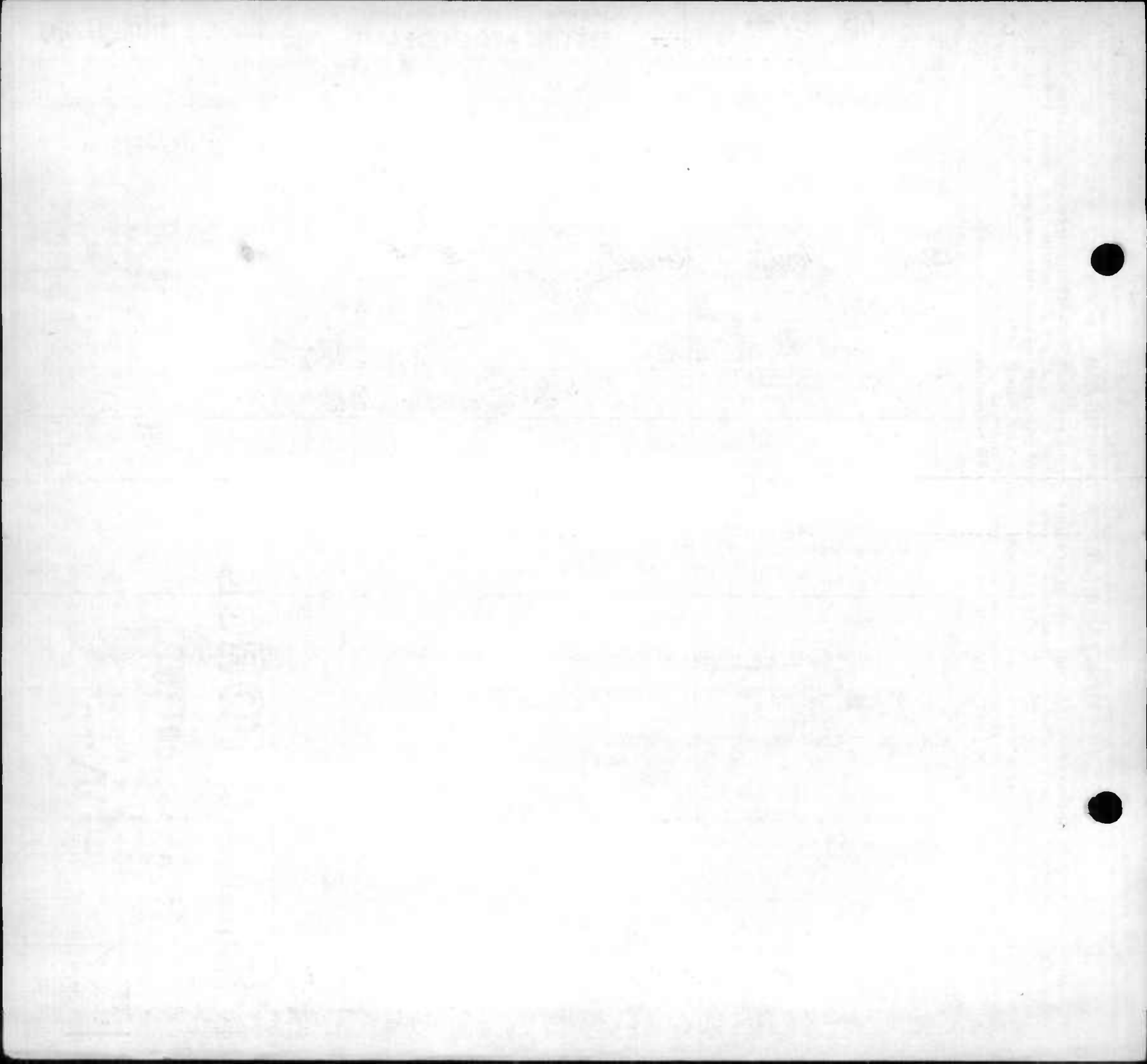
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0719	
BIRTH NO. 65 0719		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN T. LEIPOLD Jr.		2. DATE AND HOUR OF DEATH 1-19-65 7:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSP.				A. STATE MARYLAND B. COUNTY 27-48			
				C. CITY OR TOWN Baltimore			
				D. STREET ADDRESS 622 Tunbridge Rd			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-18-25	9. AGE (In years last birthday) 39	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		11. BIRTHPLACE (State or foreign country) Baltimore
				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOHN T. LEIPOLD Sr.				14. MOTHER'S MAIDEN NAME Margaret De-Wees			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WAR II				16. SOCIAL SECURITY NO. 216-16-8007		17. INFORMANT Mrs. Marilyn A. Leipold wife	
				ADDRESS 622 Tunbridge Rd Balto. Md 21212			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 45 minutes	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(B) DUE TO Peritonitis		5 days	
				(C) pancreatitis - acute			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-14-65 to 1-19-65, that (I) (we) last saw the deceased alive on 1-14-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. [Signature]		23B. DATE SIGNED 1-19-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 22/65		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Eugenia K. Seitz		ADDRESS Seitz Funeral Home Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0720				
BIRTH NO. 65 0720					M.E. CASE NO. BUTCHER				
1. NAME OF DECEASED (Type or Print) BUTCHER - CORA ESTELLE					2. DATE AND HOUR OF DEATH 1/18/65 8:45 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-14				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI-HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 1029 WOODHEIGHTS AVE - #11									
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1-3-15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner			10B. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Robert D. Butcher			14. MOTHER'S MAIDEN NAME Mary Gosnell						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-6527		17. INFORMANT Harry C. Sterner			ADDRESS 1029 Wood Heights Ave	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest					Pnt. 8:40 PM				
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD					2				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1/17/65 19 to 1/18/65 19, that (I) (we) last saw the deceased alive on 1/18/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. Any					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> E. Any		23B. DATE SIGNED 1/18/65		
23C. PHYSICIAN'S NAME (Type) Aaron Any					23D. ADDRESS SINAI-HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Jan. 22-1965		24C. NAME OF CEMETERY OR CREMATORY Poplar Grove		24D. LOCATION (City, town, or county) (State) Harrow, Baltimore Co. Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR George R. Ruff, Jr. 3631 Falls Road				



cdg: 42-24-621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 0721

BIRTH NO. 65 0721

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

J.

Charles Adams

2. DATE AND HOUR OF DEATH

1-19-65

8:35 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3500 O'Donnell Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

5-5-98

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Steward

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Adams

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
215-10-9368

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 433.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Shock
DUE TO

1 1/2 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Congestive Heart Failure
DUE TO

24 hours

(C) Cardiac Arrhythmia

?

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 19 19 65 to January 19 19 65,
that (I) (we) last saw the deceased alive on January 19, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert Cooke

M.D.

Attending
Phys. ☐Med.
Director ☐Stoll
Phys. ☒

23B. DATE SIGNED

1-19-65

23C. PHYSICIAN'S
NAME (Type)

Robert Cooke

M.D.

23D. ADDRESS

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-23-1965

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

25B. NAME OF REGISTRAR

Robert E. Farley

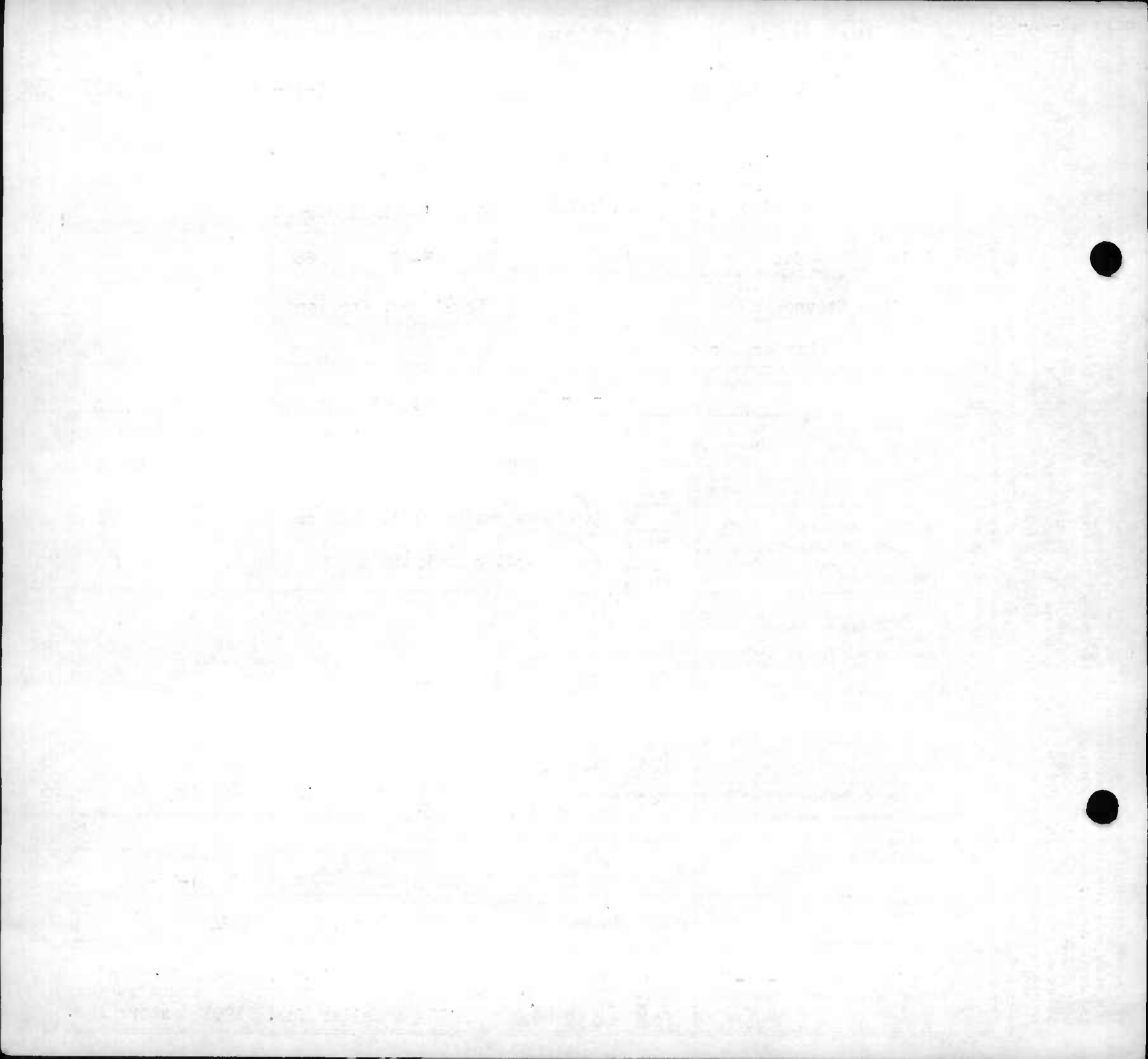
25C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

WILSON HEATH

2. DATE AND HOUR PRONOUNCED DEAD

1-18-65

1:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1128 WILMOT COURT

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1128 Wilmot Court - 21202

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

7-14-84

9. AGE (In years
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CUSTODIAN

10B. KIND OF BUSINESS OR INDUSTRY

SCHOOL

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Sylvia

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WW1 1922 - 1926

16. SOCIAL
SECURITY NO.

214-01-0045

17. INFORMANT

ADDRESS

SYLVIA CAIN 1203 ENSOR ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) ~~Massive retroperitoneal hemorrhage~~
DUE TO

Rupture of abdominal aneurysm

(B)
DUE TO(C)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-22-65

23C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

(State)

5501 Frederick Ave

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

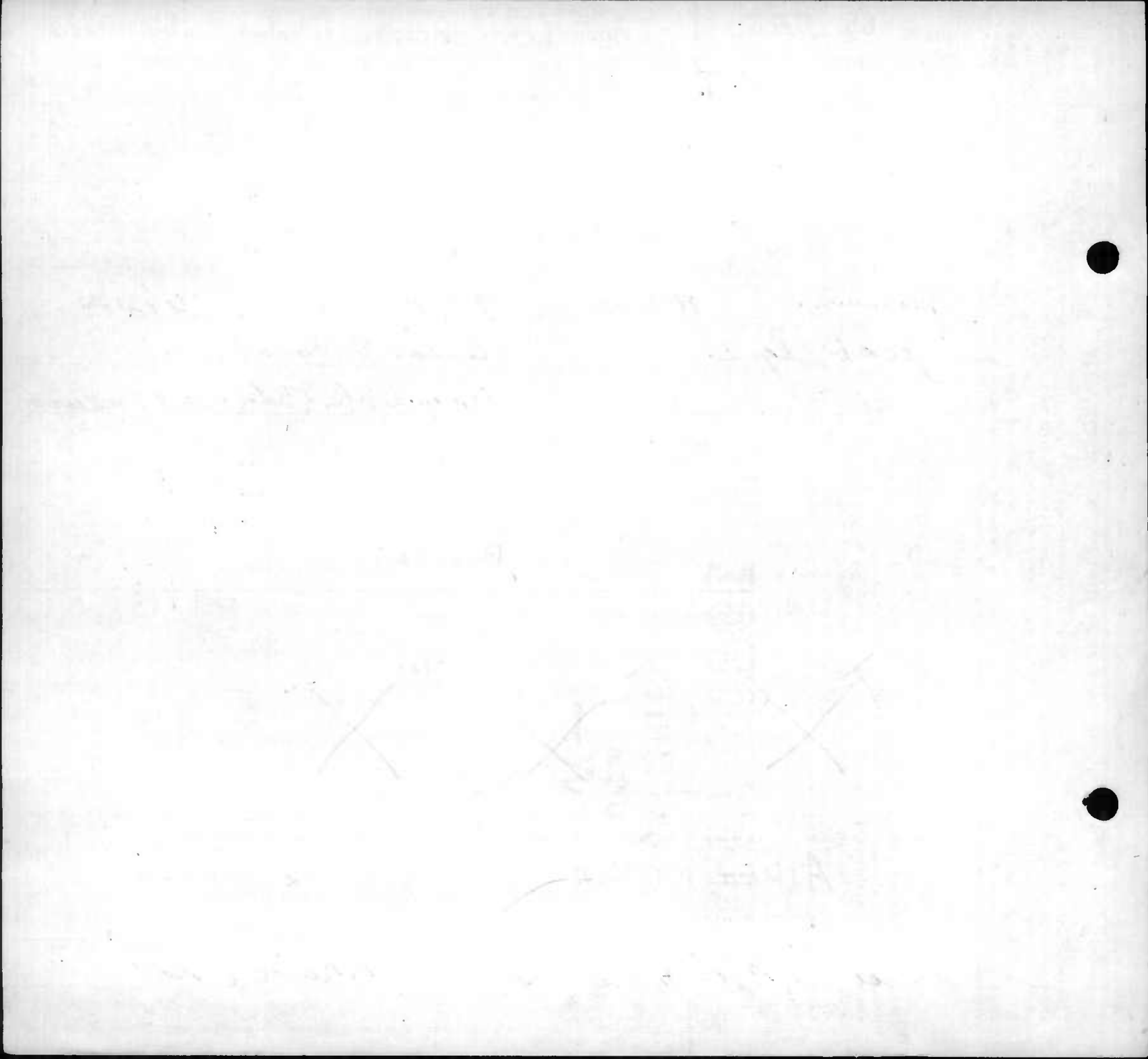
Joseph E. Pock Jr. 1304 N. Central Ave

WALTER BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0723	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0723					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ADELYNE T. DODD			2. DATE AND HOUR OF DEATH 1-20-65 10:45 A.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION B LUTHERAN HOSP			A. STATE MD B. COUNTY BALTIMORE Balto.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00		
			D. STREET ADDRESS (If rural, give location) 3018 ROCKWOOD AVE		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 7-7-1897	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) July 7-1897	
13. FATHER'S NAME Jacob Agnes			14. MOTHER'S MAIDEN NAME Anna O. Dodd		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. uninsured		
17. INFORMANT Clarence John Dodd			ADDRESS 3018 Rockwood		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 545X I SHOCK DUE TO MASSIVE HEMATEMESIS OR HEMOPTYSIS			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH one half hour one month one week		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension			for years		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED X		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) X	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) X		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? X	
22. I certify that (I) (this hospital) attended the deceased from 1-1-19 65 to 1-20-19 65, that (I) (we) last saw the deceased alive on 1-20-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AIDEH KOBLER M.D.				23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) AIDEH KOBLER				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Greenland	
24D. LOCATION Pikesville Md.		24E. NAME OF REGISTRAR Robert E. Fisher M.D.		24F. FUNERAL DIRECTOR Frank H. Harrell	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR Frank H. Harrell	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0724		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0724	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Land, Edmonia		2. DATE AND HOUR OF DEATH 1/19/65 1:00 PM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. 1401		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1807 Linden Ave.	
5. SEX M F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH May 8, 1918	9. AGE (In years last birthday) 47	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) D.C.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Porter		14. MOTHER'S MAIDEN NAME Isabelle Brown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Cecilia Eberhart-1807 Linden Ave		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cerebral and cardiovascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH hrs		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1:00 PM 1/19/65 to 1:00 PM 1/19/65, that (I) (we) last saw the deceased alive on 1:00 PM 1/19/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE David W. Morse		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/20/65		23C. PHYSICIAN'S NAME (Type) David W. Morse	
23C. PHYSICIAN'S NAME (Type) David W. Morse		23D. ADDRESS University Hospital Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm. J. Blatnik Jr. - 1701 McCellan		ADDRESS Baltimore	

10/1/20

10/1/20



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY T. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1965

12:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

700 Fleet St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

128 Willard St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

divorced

8. DATE OF BIRTH

6/21/93

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Montgomery Johnson

14. MOTHER'S MAIDEN NAME

Elizabeth Marks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Irene Simpson (Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Exposure to cold
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Carroll Park

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Carroll Park off Washington Blvd.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 19 65 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Exposed to cold

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 22/65

23C. NAME of CEMETERY or CREMATORY

Balto. County Balto. Ind.

23D. LOCATION

(City, town, or county)

(State)

Balto. Ind.

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

Witzke, 4101 Edmondson Ave

ADDRESS

WALLLEY POLICE

CHAP. COURTNEY

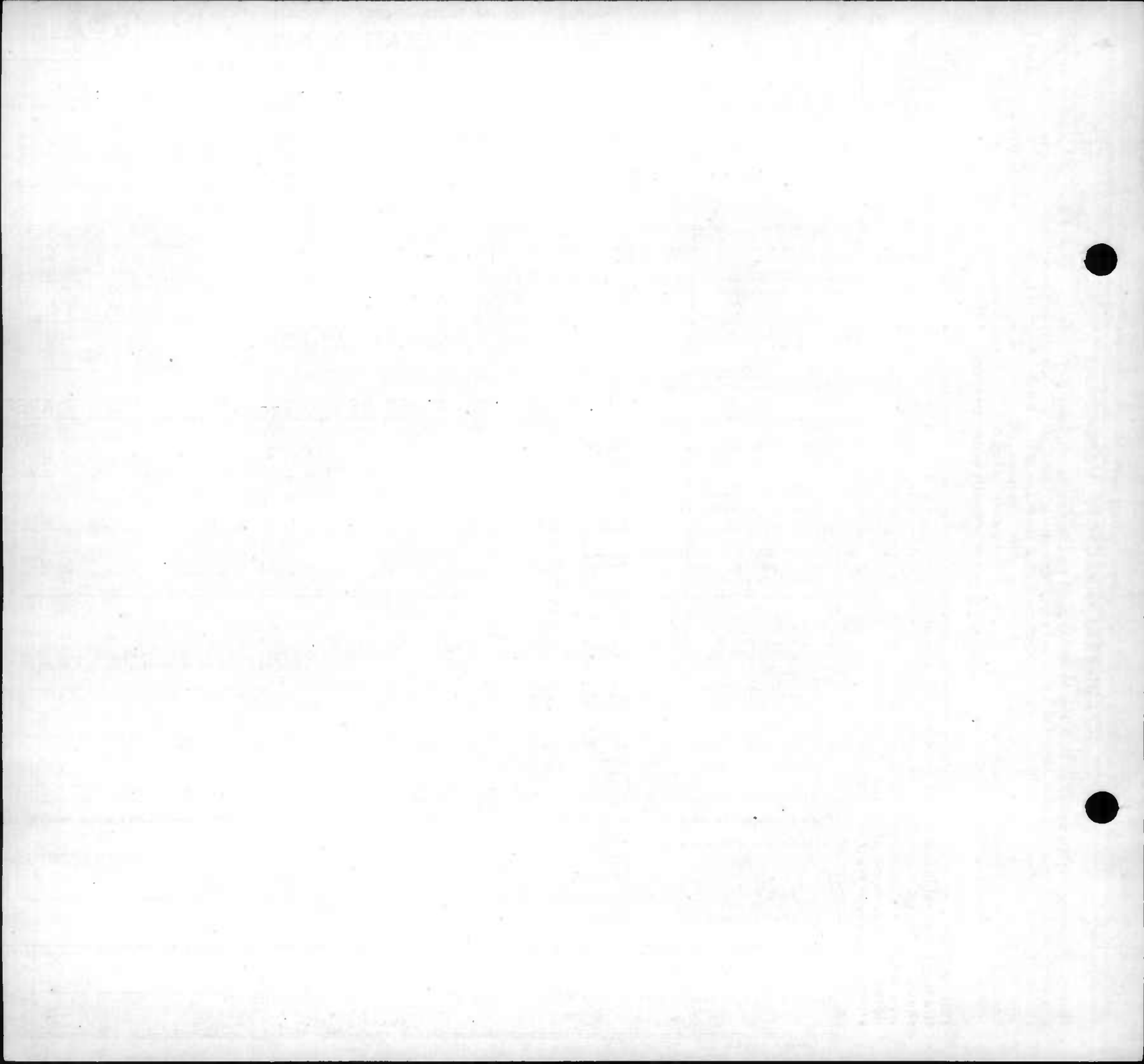
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1-2-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0726				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0726	
1. NAME OF DECEASED (Type or Print) FLYNN, NORTON DENNIS				2. DATE AND HOUR OF DEATH 1-20-65 1:15A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 21207 5535 FOREST PARK AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-20-40	9. AGE (In years last birthday) 24	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN FLYNN				14. MOTHER'S MAIDEN NAME VIOLET DAVIDSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214409795		17. INFORMANT ADDRESS ST. AGNES RECORDS--CATON & WILKENS AVES				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SCOLIOSIS THORACOLUMBAR SPINE				CAUSE OF DEATH (A) RESP COLLAPSE (OF 48 hrs) 2° to BALD PLEURAL EFF. (B) 2° to HODGKINS DISEASE OF ENTIRE SUP MEDIASTINUM (C) PARA AORTIC NODES & EXTENSION TO STOMACH & MULTIPLE ULCERS, PANCREAS, ESOPH HIATUS				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 1-13-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHECTOMY 1-6-65 TUMOR BLOCK OF ESOPH		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 29 19 64 to JANUARY 20 19 65, that (I) (we) last saw the deceased alive on JANUARY 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Henry R. DeBault, M.D.				23B. DATE SIGNED 1-20-65					
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY OR CREMATORY Lorraine PK		24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR Walter J. W. 4101 Edmondson			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 0727					
BIRTH NO. (19) 65 0727 M.E. CASE NO. 65 0727 1. NAME OF DECEASED (Type or Print) Ernest, Charles R.					2. DATE AND HOUR OF DEATH 1/20/65 12 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-31 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 619 S. Beechfield Ave, 29					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12/23/20		9. AGE (In years last birthday) 44		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patrolman			10B. KIND OF BUSINESS OR INDUSTRY Balto City Police Dept.			11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles A. Ernest					14. MOTHER'S MAIDEN NAME Theresa Arata					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II 2/3-12-45					16. SOCIAL SECURITY NO. 213-12-4518		17. INFORMANT M. Ernest (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction (anterior)					19. INTERVAL BETWEEN ONSET AND DEATH a few hours					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that FF (this hospital) attended the deceased from 1-20-1965 to 1-20-1965 , that (I) (we) last saw the deceased alive on 1-20-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE F. D. Wiley					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-20-65		
23C. PHYSICIAN'S NAME (Type) F. D. Wiley					23D. ADDRESS St. Agnes Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 25/65		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Balto. 29-Md		24D. LOCATION (City, town, or county) (State) Md				
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR W. H. W. 4101 Edmondson			ADDRESS an	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

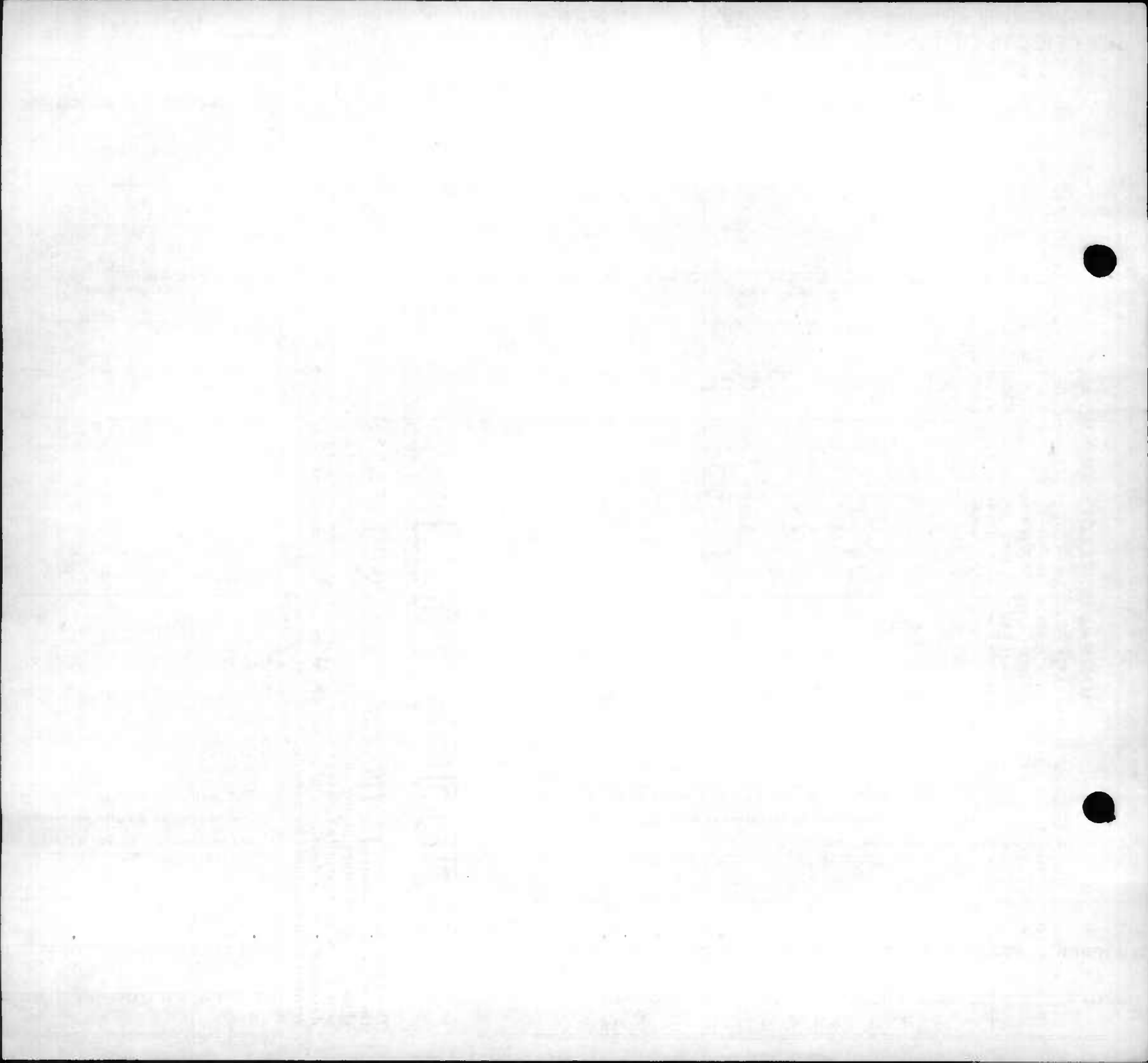
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0728	
BIRTH NO. 65 0728		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Michael J. Votta Sr.		2. DATE AND HOUR OF DEATH 1/19/65 3:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital				A. STATE Maryland B. COUNTY 3-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 307 S. High St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-31-1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Reired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Votta				14. MOTHER'S MAIDEN NAME Mary Azzato			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 219-30-9785		17. INFORMANT ADDRESS Michael J. Votta Jr. 307 S. High St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Carcinomatosis		4 mos.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cecal Carcinoma			
				(C) AS C-V Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (we) (this hospital) attended the deceased from 1/19 19 65 to 1/19 19 65, that (I) (we) last saw the deceased alive on 1/19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE (Signature)				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23-65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Frank Della Luce		ADDRESS 322 S. High St.	

RECEIVED
JAN 10 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0729		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0729 7	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY GIRL PARSONS		2. DATE AND HOUR OF DEATH 11/10/65 8:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-03			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 38 E. Barney Street			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Jean Rolf			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 774X I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Immaturity DUE TO			
ANTECEDENT CAUSES		(B) Premature Labor DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 11/10/65 19 to 11/10/65 19, that (we) last saw the deceased alive on 11/10/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald M. Wood		M.D. WOOD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 11/19/65
23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD, M.D.		23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) JAN 20 1965		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Feltz	
25C. FUNERAL DIRECTOR		ADDRESS MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

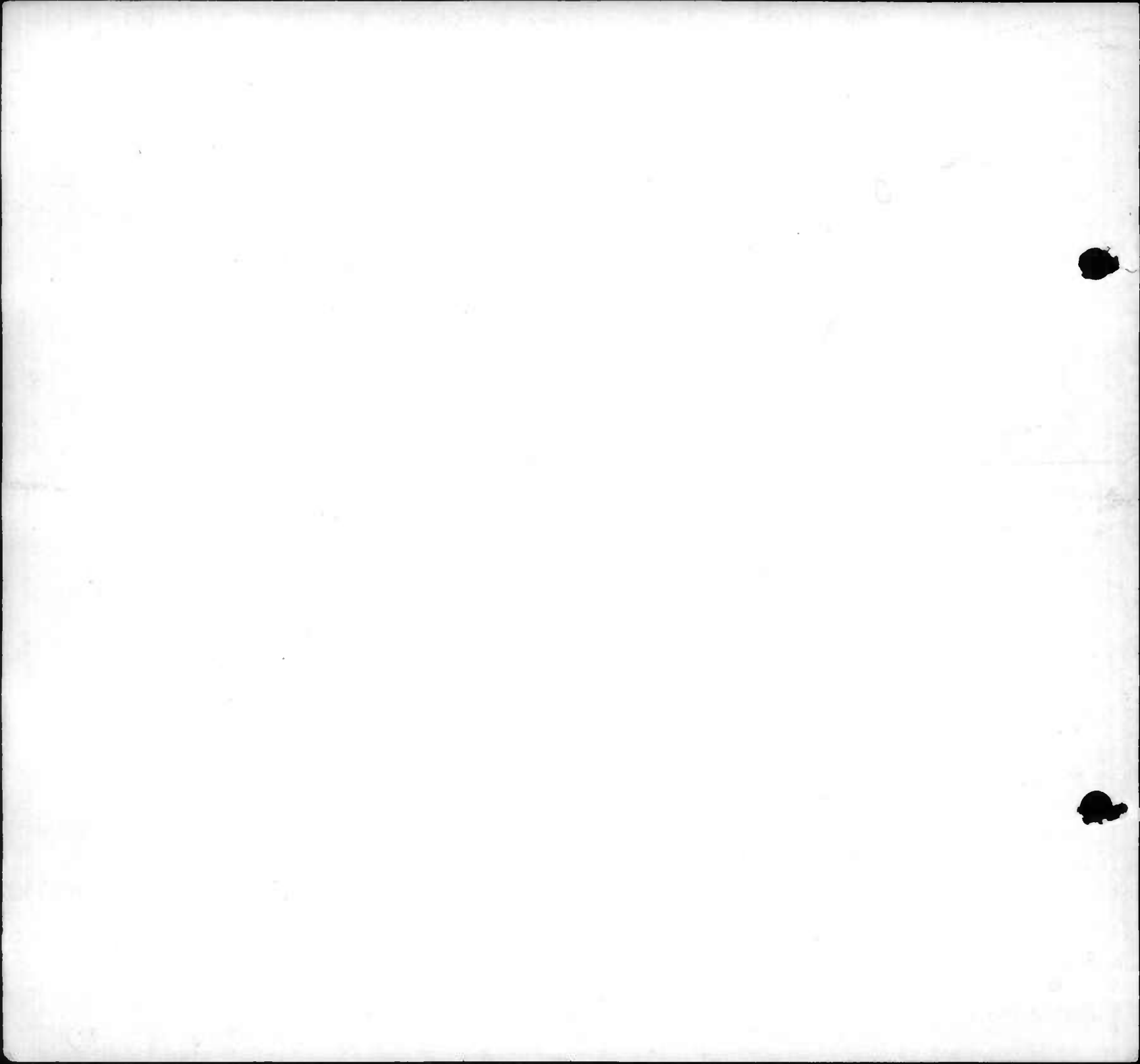
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
<div style="display: flex; justify-content: space-between;"> C-365 65 0730 </div>				<div style="display: flex; justify-content: space-between;"> 65 0730 </div>	
CERTIFICATE OF DEATH					
BIRTH NO. <i>65 01334</i>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Cotthun Infant Boy</i>		2. DATE AND HOUR OF DEATH <i>1/13/65</i> <i>6:00 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hosp.</i>		A. STATE <i>MD</i> B. COUNTY <i>Hanover</i>			
5. SEX <i>Male</i>		6. RACE <i>Ames</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Infant</i>	
8. DATE OF BIRTH <i>1-11-65</i>		9. AGE (In years last birthday) <i>2</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Berkley Cotthun</i>		14. MOTHER'S MAIDEN NAME <i>Choban, Alice</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Record -</i> ADDRESS	
18. <i>773.0 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Hyaline Membrane disease</i>			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-11-1965</i> to <i>1-13-1965</i> , that (I) (we) last saw the deceased alive on <i>1-13-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>GEORGE HEBEKA</i> M.D.				23B. DATE SIGNED <i>1/13/1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>George Hebeke</i>				23D. ADDRESS <i>2724 No. Charles St -</i>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <i>JAN 19 1965</i>		24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHO</i>	

AMERICAN COLLEGE

#-520

THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

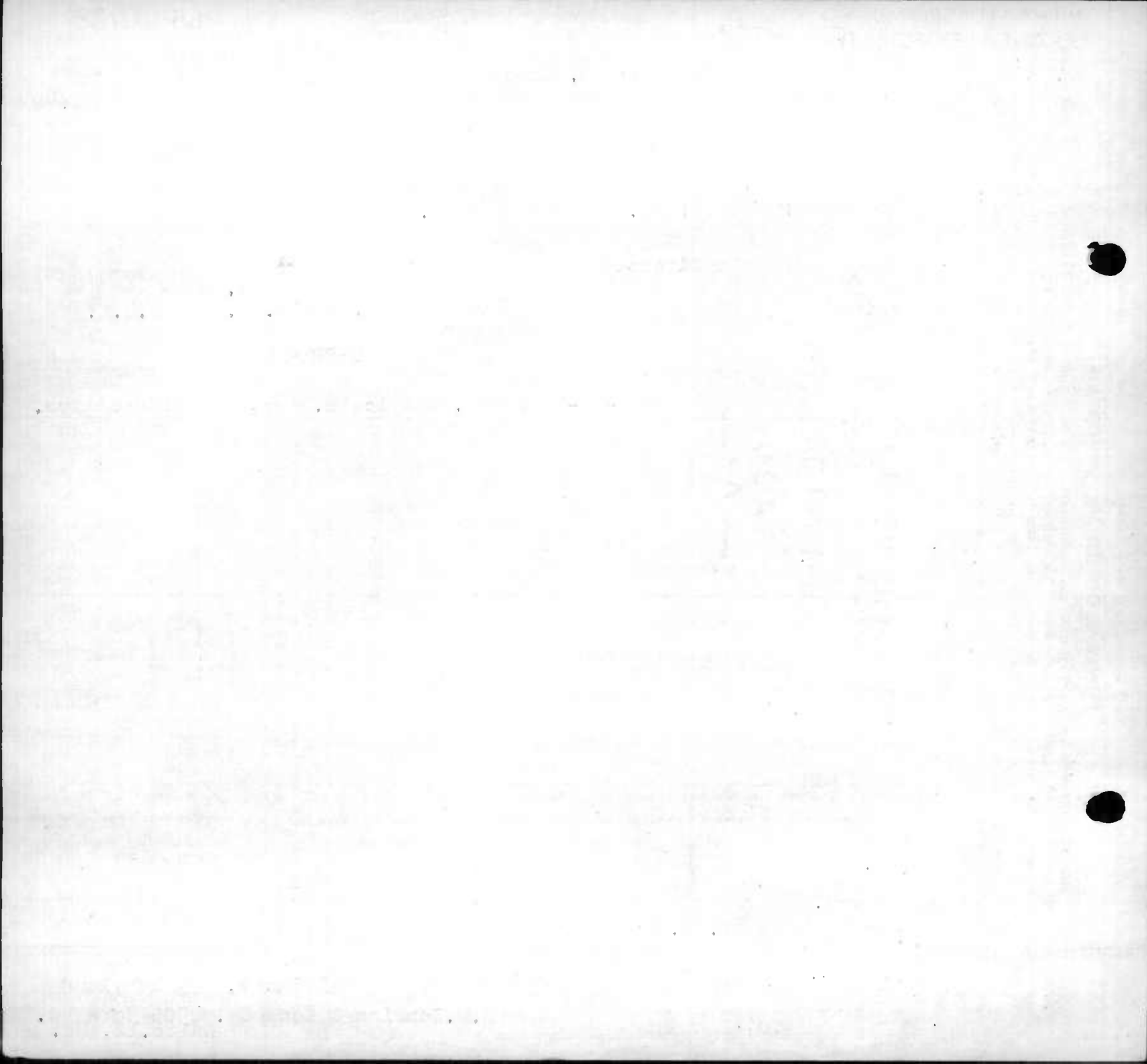
BIRTH NO. <u>64-33554</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 0731</u>	
1. NAME OF DECEASED (Type or Print) <u>DENNIS H. HINES</u>				2. DATE OF DEATH <u>1-2-65</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2707 Cheswolde Road #9</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2707 Cheswolde Road #9</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>12-5-64</u>	9. AGE (In years last birthday) <u>1 mo.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>FRANCIS GARY</u>			14. MOTHER'S MAIDEN NAME <u>DOYLE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FATHER</u>	
18. <u>337.1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration</u> INTERVAL BETWEEN ONSET AND DEATH <u>TRACHEO-ESOPHAGEAL FISTULA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
MEDICAL CERTIFICATION					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II <u>2</u>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-5-64</u> to <u>12-28-64</u> , that (I) (we) last saw the deceased alive on <u>12-30-64</u> and that in (my) (our) opinion death occurred at <u>7:40 p.m.</u> from the causes and on the date stated above.					
23A. SIGNATURE <u>EC Crum</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23B. ADDRESS <u>Sinai Hospital</u>		23C. DATE SIGNED <u>1/2/65</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>JAN 19 1965</u>		24C. NAME OF CEMETERY, CREMATORY, OR PLACE OF INTERMENT <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0732</u>	
BIRTH NO. <u>65 0732</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LAWRENCE B. EMGE</u>		2. DATE AND HOUR OF DEATH <u>Jan 11/19/65</u> <u>12⁰⁰ PM.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE, 5</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, 5</u> D. STREET ADDRESS (If rural, give location) <u>1036 N. BROADWAY</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>10-24-81</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Artist</u>	11. BIRTHPLACE (State or foreign country) <u>Md. Baynesville, Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN EMGE</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA BERRYMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>420-30-1490</u>	17. INFORMANT ADDRESS <u>Mrs. Beatrice M. Rice, 5328 Midwood Ave.</u>		
18. <u>420-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardiac Arrhythmia</u> DUE TO <u>777</u> (B) <u>ASCVD</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>55</u> to <u>1/19</u> 19 <u>55</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> 19 <u>55</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. R. Caldwell</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>1/20/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. R. Caldwell</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/23/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 0733	
BIRTH NO. 65 0733		M.E. CASE NO.		2. DATE AND HOUR OF DEATH Jan. 19, 1965	
1. NAME OF DECEASED (Type or Print) LAURA Lauree Lee Rupprecht		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) Harford Gardens N.H.		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			
8. DATE OF BIRTH 8-24-1880		9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Walter	
14. MOTHER'S MAIDEN NAME Frances White		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0484	
17. INFORMANT Mrs. Irma R. Muhly		18. ADDRESS Above		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis		21. INTERVAL BETWEEN ONSET AND DEATH 1 year		22. I certify that (I) (this hospital) attended the deceased from Jan 10 1965 to Jan 19 1965 , that (I) (we) lost saw the deceased alive on Jan 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Loy M. Zimmerman		23B. DATE SIGNED 1/20/65		23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-65		24C. NAME OF CEMETERY or CREMATORY Immanuel Lutheran	
24D. LOCATION Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Fabyana	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd.		26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

MEDICAL CERTIFICATION

V.S. 153

1-26-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

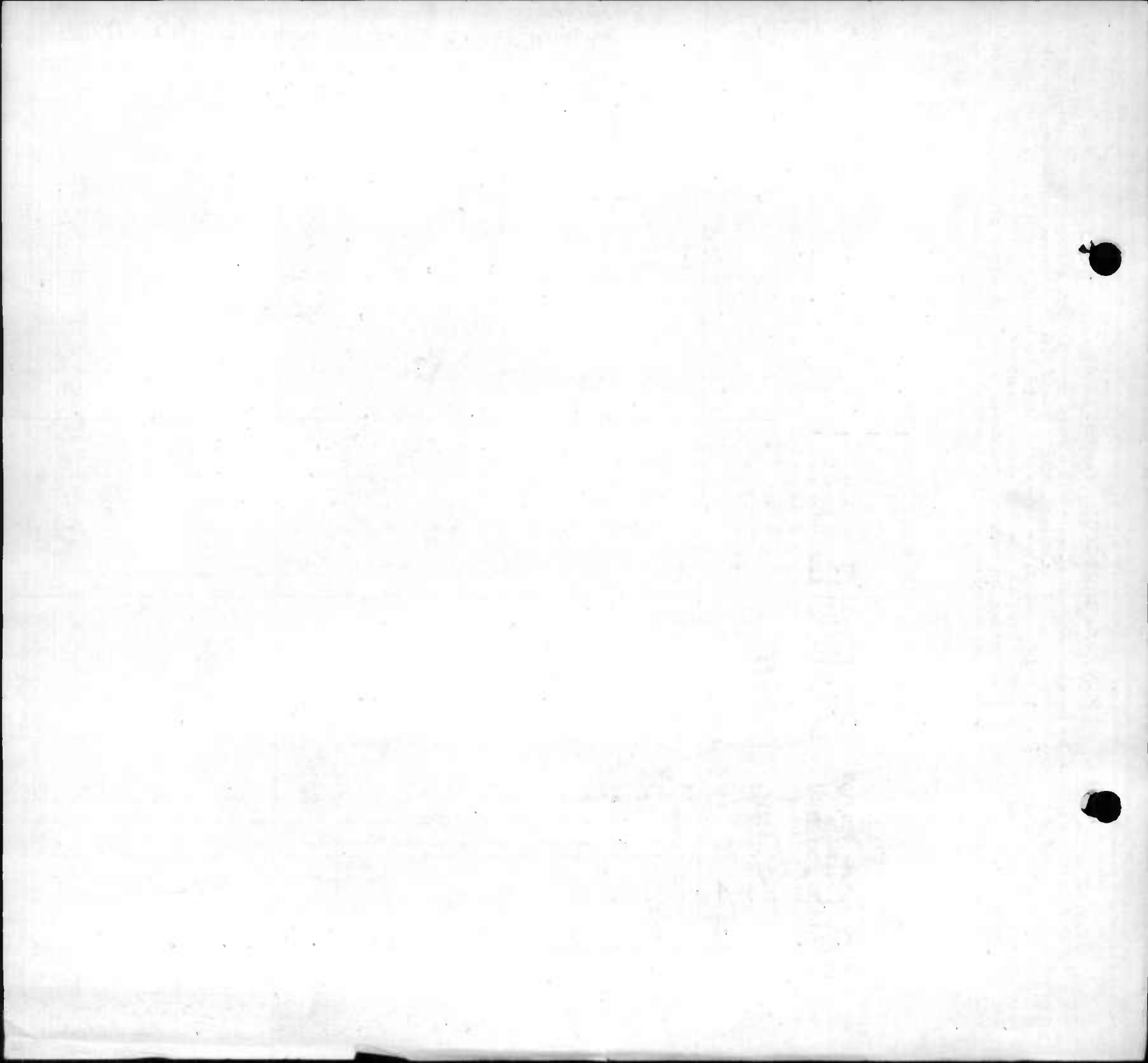
65 0734		BALTIMORE CITY HEALTH DEPARTMENT		X Registered No.		65 0734	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Fankhanel, Sophia M.</u>				2. DATE AND HOUR OF DEATH <u>January 19, 1965 9:07 P.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>611 Seabrook Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widow</u>	8. DATE OF BIRTH <u>March 22, 1886</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joe Didusch DEC</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Doetsch DEC</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-12-3429</u>		17. INFORMANT ADDRESS <u>W^M R. FANKHANEL 5208 LOCH RAVEN BLVD.</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Myocardial infarction</u> DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>(Yes)</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 4</u> 19 <u>65</u> to <u>January 19</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>January 19 (2pm) 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Yimin Jiltsune</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 19, 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Pill Sun Yim</u> M.D.				23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-23-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER CEM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR <u>HENRY W. JENKINS & SONS</u>		ADDRESS <u>4905 YORK RD.</u>	

Transfer from
the [unclear] [unclear] [unclear]
[unclear] [unclear] [unclear] [unclear]
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

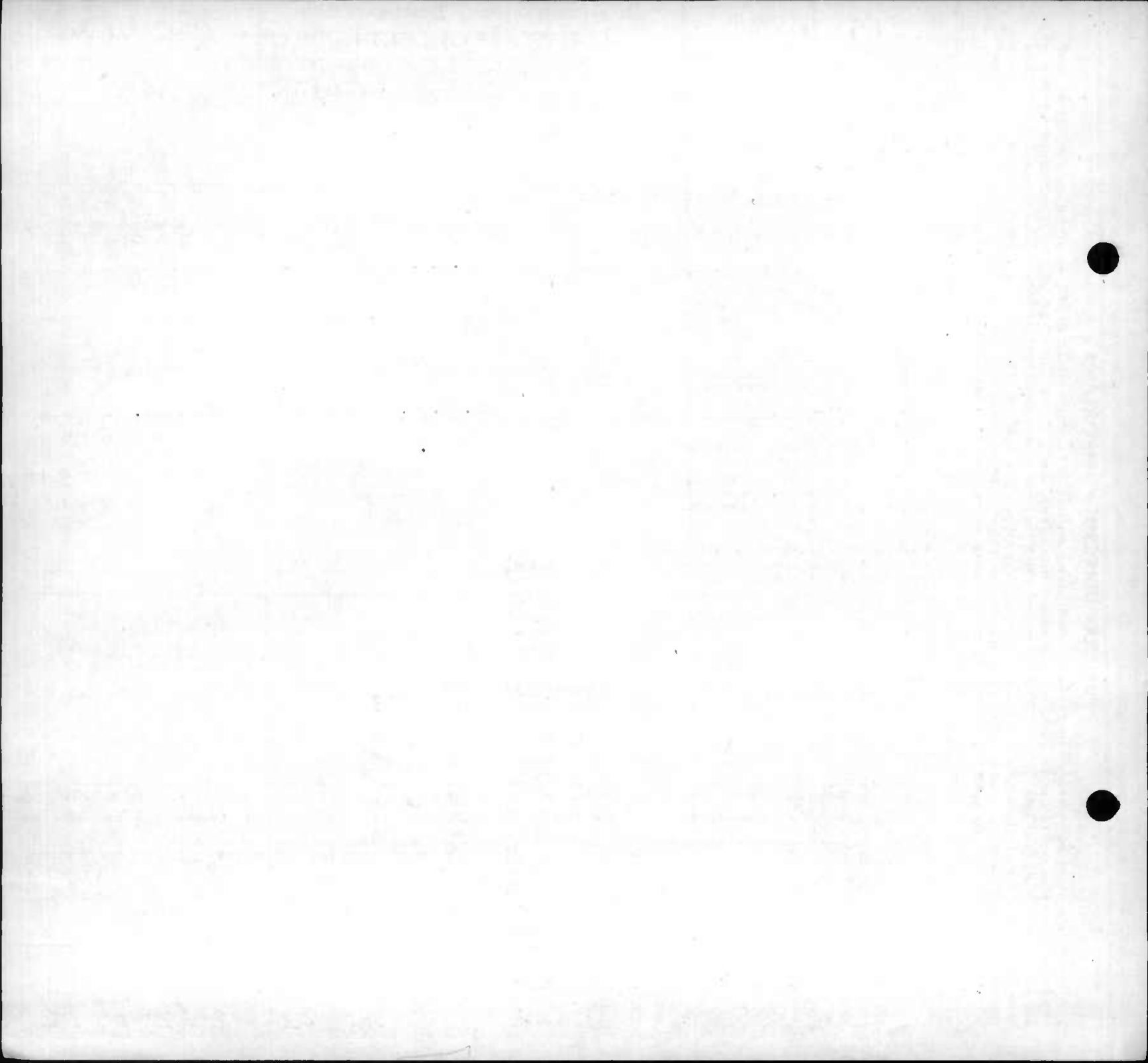
BIRTH NO. 65 0735		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 0735	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Margaret E. Willing			2. DATE AND HOUR OF DEATH January 20, 1965 1 3 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Resid's Care Home FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 218 Ridgewood Road Baltimore, Maryland 21210			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2445 North Charles Street 21218		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 28, 1875	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York County, Virginia	
13. FATHER'S NAME ? Evans			14. MOTHER'S MAIDEN NAME ? 		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas J. Willing Wynnewood, Pennsylvania	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Advanced Atherosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocarditis Hypertension			CAUSE OF DEATH Coronary Heart Disease Cerebral Hemorrhage Advanced Atherosclerosis Myocarditis Hypertension		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 19 1965 to Jan 20 1965 , that (I) (we) last saw the deceased alive on Jan 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
23A. SIGNATURE W. H. Woody				23B. DATE SIGNED 1-21-65	
23C. PHYSICIAN'S NAME (Type) W. H. Woody			23D. ADDRESS 1403 Park Ave. Balto. Md. 21217		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/1965		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			
25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Wm. F. Dickman & Sons Baltimore, Md. 17 North & Pa. Avenues			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

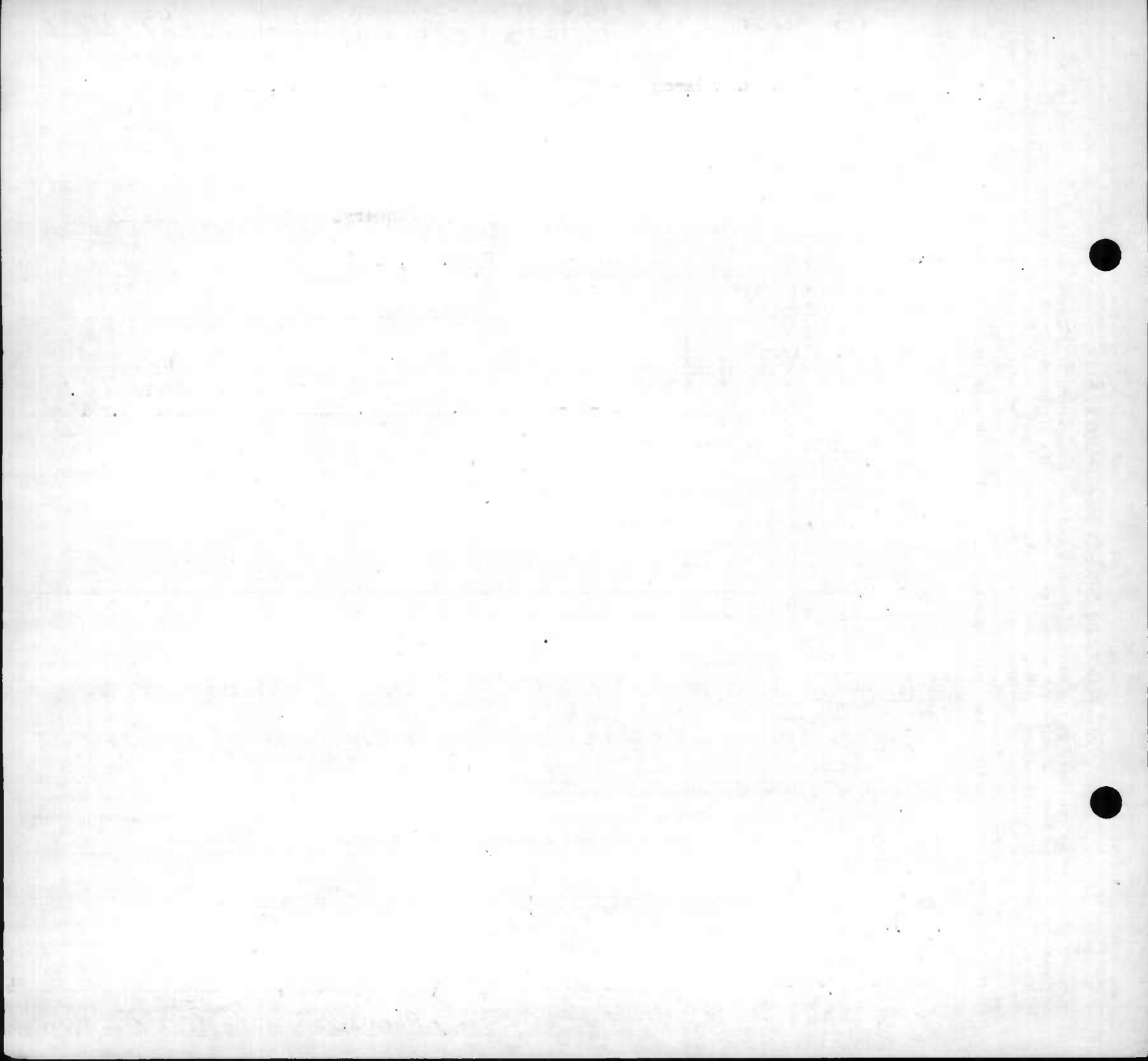
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 0736					CERTIFICATE OF DEATH					Registered No. 65 0736									
M.E. CASE NO.										2. DATE AND HOUR OF DEATH									
1. NAME OF DECEASED (Type or Print) <u>Ellen Schoeneman</u>										January 19, 1965 8:38 AM M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2502 Eutaw Place Baltimore, Maryland 21217</u>										A. STATE <u>Maryland</u> B. COUNTY <u>13-01</u>									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>									
										D. STREET ADDRESS (If rural, give location) <u>2502 Eutaw Place 17</u>									
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 14, 1883</u>		9. AGE (In years last birthday) <u>81</u>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>					11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				
13. FATHER'S NAME <u>Joseph Adelsdorf</u>										14. MOTHER'S MAIDEN NAME <u>Carrie Eliel</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Mr. J. J. Miller</u>					ADDRESS <u>Box 5803 Pikesville, Md. 8</u>				
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>										INTERVAL BETWEEN ONSET AND DEATH									
(A) <u>Hypertensive Arteriosclerotic Heart Disease</u>										<u>10 yrs.</u>									
(B) <u>Coronary Heart Failure + Arteriosclerotic Heart Disease</u>										<u>3 yrs.</u>									
(C) <u>Generalized Arteriosclerosis</u>										<u>10 yrs.</u>									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										<u>Cerebral Sclerosis</u>									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>September 2nd 1964</u> to <u>January 19th 1965</u> , that (I) (we) last saw the deceased alive on <u>January 19th 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>8:38 AM</u>																			
23A. SIGNATURE <u>Dr. H. William Primackoff</u>										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <u>January 20, 1965</u>				
23C. PHYSICIAN'S NAME (Type) <u>DR. H. WILLIAM PRIMACKOFF</u>										23D. ADDRESS <u>Emersonian Apartments Baltimore, Md.</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>1/21/1965</u>					24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Hebrew Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Farber M.D.</u>					25C. FUNERAL DIRECTOR <u>Wm. J. Dickson & Sons</u>					ADDRESS <u>Baltimore, Md. 17 North Pa. Avenue</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0737	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0737		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Luther Roy Wilson			2. DATE AND HOUR OF DEATH January 19, 1965 5-32 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4207 Penhurst Avenue Baltimore, Maryland 21215			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-41 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4207 Penhurst Avenue 21215		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 21, 1882	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Boonsboro, Maryland
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Scott K. Wilson		
14. MOTHER'S MAIDEN NAME Cara V. ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		
16. SOCIAL SECURITY NO. 215-03-4619			17. INFORMANT Mrs. Scott K. Wilson Baltimore, Md. 15		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 491X + 260X ASCVD cont. osteoarthritis, BPH Diabetes mellitus & Kimmelstiel Wilson dis. years			CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) 5 days DUE TO (C) Interval between onset and death		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21H. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar 13, 1956 to Jan 18, 1965 , that (I) (we) last saw the deceased alive on Jan 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Whittlesy				23B. DATE SIGNED Jan 20, 1965	
23C. PHYSICIAN'S NAME (Type) Philip Whittlesy				23D. ADDRESS 600 W. Belvedere 21210	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/21/65		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. F. Dickner & Sons Baltimore, Md. 21217			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **65 0738**

BIRTH NO. **65 0738**

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Geneva Cohen

2. DATE AND HOUR OF DEATH

January 18, 1965

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

**4501 Old Frederick Road
Uplands Home for Church Women
Baltimore, Maryland 21229**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4501 Old Frederick Road

29

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 24, 1879

9. AGE (In years
last birthday)

85

If Under 1 Yr.
Months: Days

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Woods Mills, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

?

Cohen

14. MOTHER'S MAIDEN NAME

Ella Dorsey Hobbs

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

17. INFORMANT

**4501 Old Frederick Rd.
Uplands Home for Church Women Balto., Md. 29**

18.

420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) **Coronary Occlusion**
DUE TO
(1) **Coronary Arterio Sclerosis**
(2) **Mycobacter**
(3) **Hypertension**

INTERVAL BETWEEN
ONSET AND DEATH

30 minutes
Gradual onset
" "
" "

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **Oct 1963** to **Jan 18 1965**,
that (I) (we) last saw the deceased alive on **Jan 16 1965** and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. H. Woody

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1-19-65

23C. PHYSICIAN'S
NAME (Type)

W. H. Woody

M.D.

23D. ADDRESS

1403 Park Ave. Balto. Md. 21217

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/20/65

24C. NAME OF CEMETERY or CREMATORY

Landon Park Cemetery Baltimore, Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

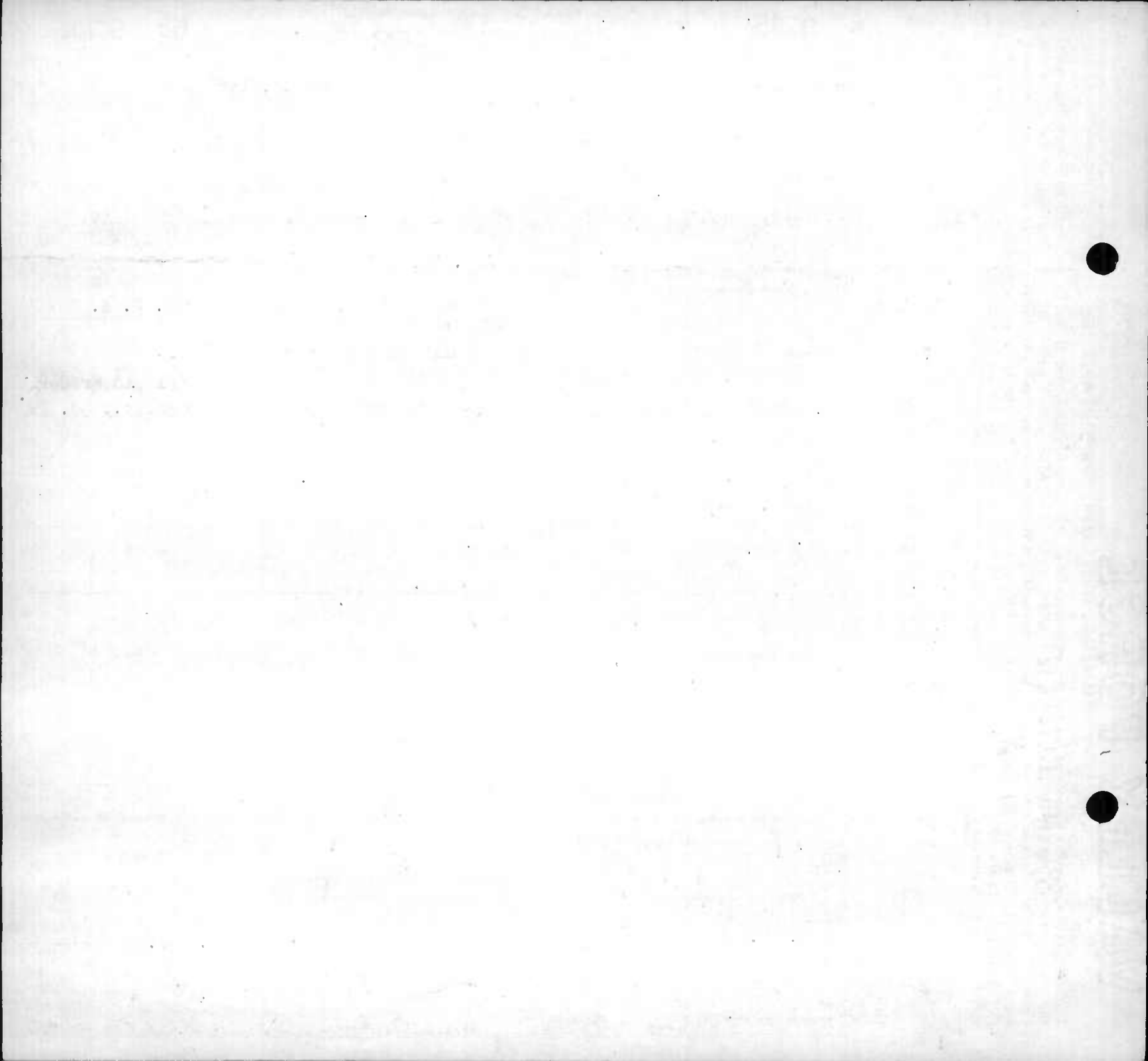
JAN 21 1965

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

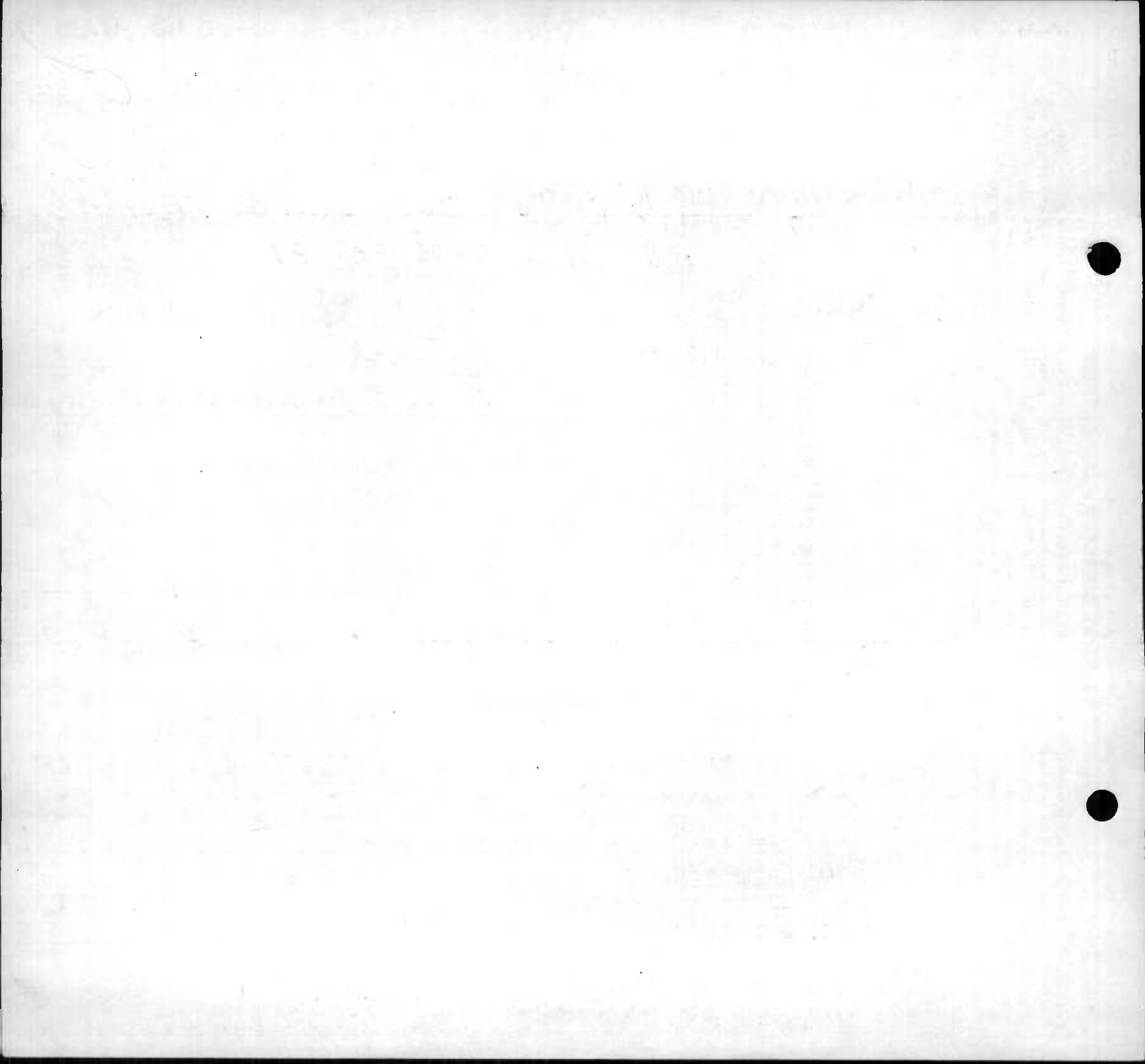
Wm. J. Fickner & Son Baltimore, Md. 17



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0739	
BIRTH NO. 65 0739		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Christina Becker		2. DATE AND HOUR OF DEATH January 19, 1965 11:20 am	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 2603	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Zone 15			
				D. STREET ADDRESS (If rural, give location) 3642 Dudley Avenue			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 6-26-83		9. AGE (In years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Thomas Heaton				14. MOTHER'S MAIDEN NAME Jane			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT George J. Becker - 3642 Dudley Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 42011 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				NIL			
19A. DATE OF OPERATION 0 NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NO		21E. INJURY OCCURRED White <input checked="" type="checkbox"/> Work <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 10:00 AM 1/19/1965 to 11:20 AM 1/19/1965 , that (I) (we) last saw the deceased alive on 11:15 AM 1/19/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. Chilimindris				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) DR C. CHILIMINDRIS				23D. ADDRESS U. M. H			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-64		24C. NAME OF CEMETERY or CREMATORY Baltimore Cem.		24D. LOCATION (City, town, or county) (State) Baltimore - Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John C. Miller, Inc.		ADDRESS 6415 Belair Rd.	



2 3 5 2

65 0740

BALTIMORE CITY HEALTH DEPARTMENT

65 0740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO. 59316

1. NAME OF DECEASED
(Type or Print)

JOHN ZDENEK

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965 7:41 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

719 N. Rose Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 22, 1889

9. AGE (In years last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Generalist

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-03-5404A

17. INFORMANT

ADDRESS

Mary Zdenek 719 N. Rose St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema and bronchial asthma.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

John E. Adams

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-21-65

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

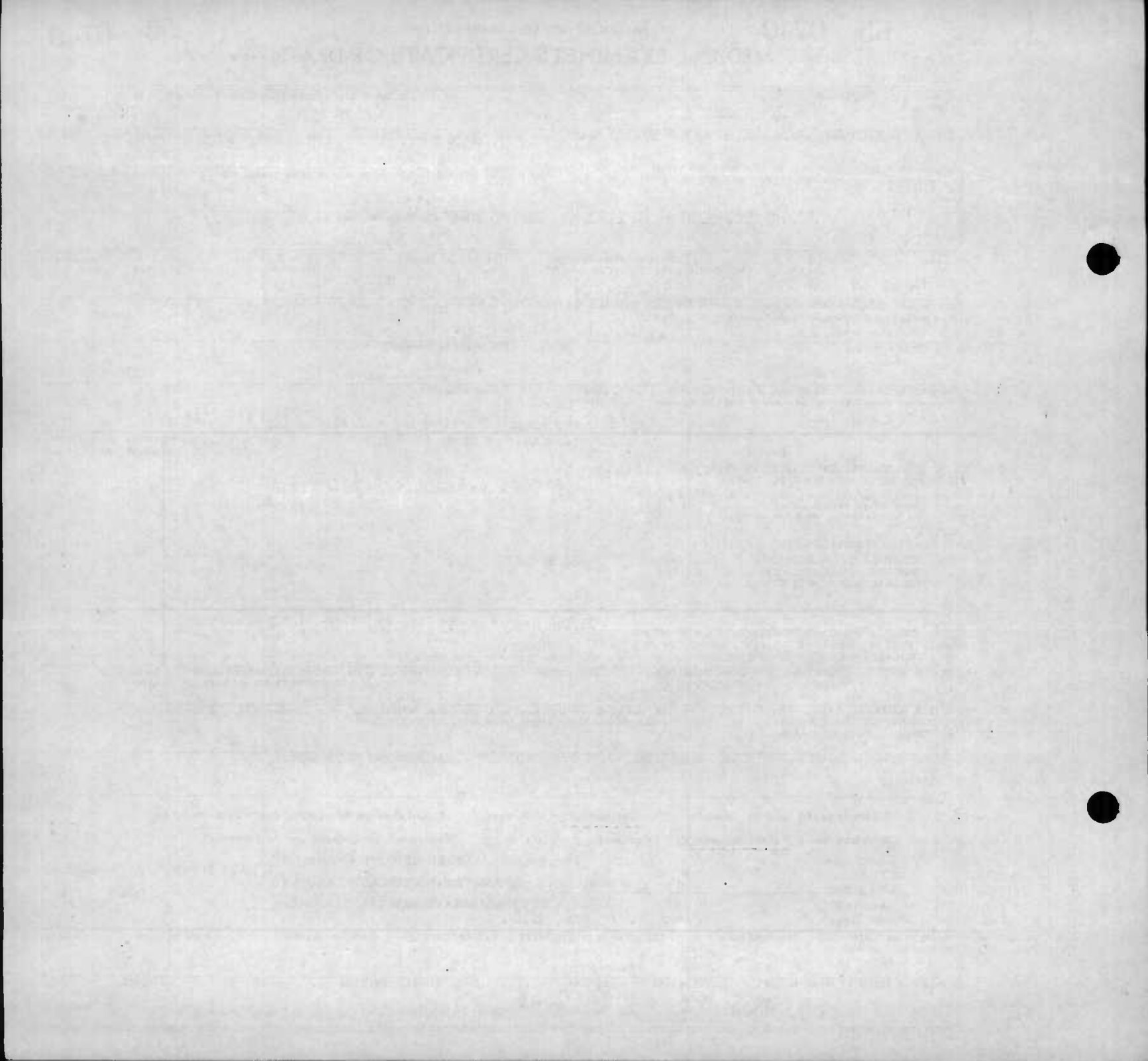
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Philip E. Czech 1211 Chosaco Ave.

ADDRESS



D-5001

65 0741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 0741

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

DUNN, THOMAS ANDREW

2. DATE AND HOUR OF DEATH

1/19/65

9:05 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md

2005

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balti

D. STREET ADDRESS (If rural, give location)

2131 WILKINS AVE.

5. SEX

MALE

6. RACE

WHITE

7. MARRIAGE STATUS (If married, give date of marriage)

NEVER MARRIED

8. DATE OF BIRTH

10/29/1896

9. AGE (In years
last birthday)

68

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MOTORMAN

10B. KIND OF BUSINESS OR INDUSTRY

TRANSIT CO.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DUNN Thomas

14. MOTHER'S MAIDEN NAME

Kelly, Marie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

213-10-0638

17. INFORMANT

ADDRESS

Goldie Dunn 2131 Wilkins Ave.

18. 4-20-1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Acute myocardial infarct, left ventricle 2 days

(B) Arteriosclerotic Heart Disease years

(C) Pulmonary Edema 1 day

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes.

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to Jan. 19 1965,
that (I) (we) last saw the deceased alive on 9:05 Jan. 19 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Vicente R. Carag Jr.

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Jan. 19/65

23C. PHYSICIAN'S
NAME (Type)

VICENTE R. CARAG JR.

M.D.

23D. ADDRESS

BON SECOURS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-23-65

24C. NAME OF CEMETERY or CREMATORY

London Park

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

25B. NAME OF REGISTRAR

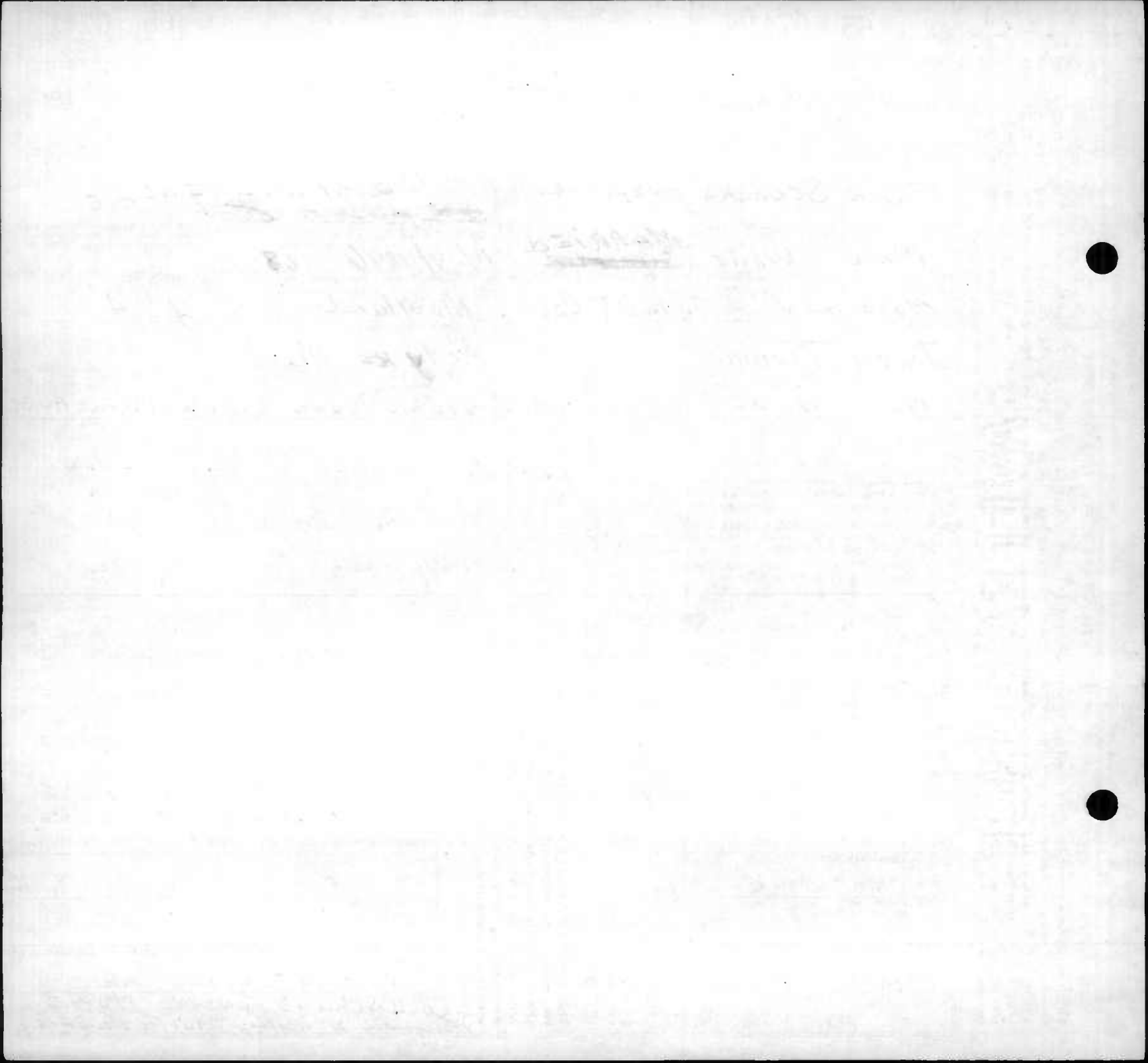
Robert E. Fisher M.D.

25C. FUNERAL DIRECTOR

GEO. L. Schwab FUNERAL HOME
Francis W. Miller 2101 Franklin Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



K 2601

46

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

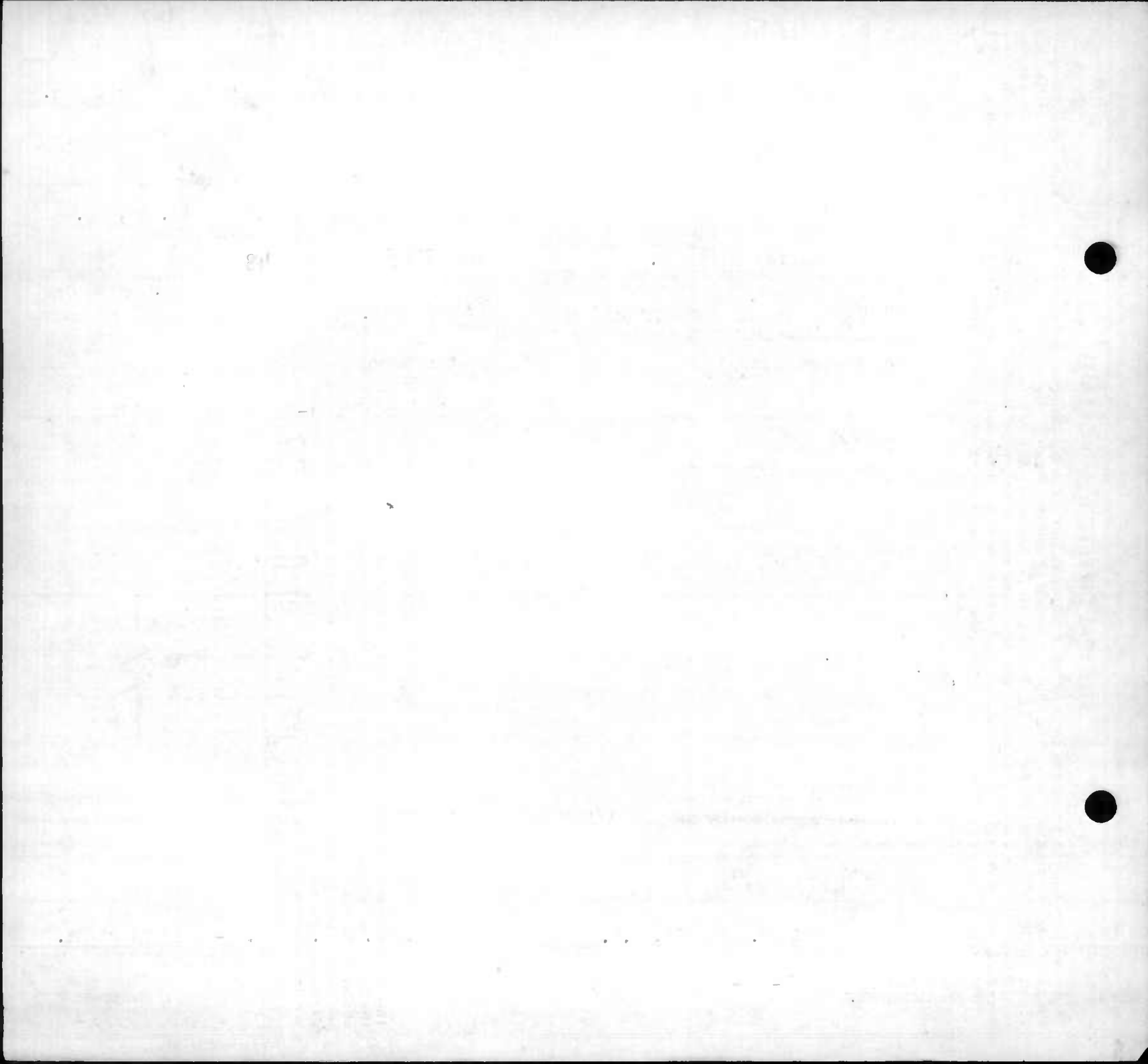
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0742	
BIRTH NO. 65 0742		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Kaiser	
2. DATE AND HOUR OF DEATH January 20, 1965 1 6 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MD. 1904		5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1830 RAMSEY STREET #23			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10B. KIND OF BUSINESS OR INDUSTRY Can Mfg.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRED KAISER		14. MOTHER'S MARRIED NAME Sophie PETERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES World War I		16. SOCIAL SECURITY NO. 215-07-9213		17. INFORMANT Elyse J. Green 302 Mardo Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Jaundice (B) Ca pancreas's head (C)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1-14-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca pancreas's head		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 11 1965 to January 20 1965, that (I) (we) last saw the deceased alive on January 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) E.H. Weiss E. H. Weiss		23D. ADDRESS M.D. 730 Ashburton St. Balto, Md. - 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-23-65		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) BALTIMORE CITY Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965			
25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR GEO. L. Schwab FUNERAL HOME 2101 Frederick Ave.			

MALE WHITE IN HADDOCK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0743				CITY HEALTH DEPARTMENT		Registered No. 65 0743	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Chapman				2. DATE AND HOUR OF DEATH 1/14/65 5:00 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital				A. STATE Maryland			
				B. COUNTY 23-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 911 Leadenhall Street Balto. 30, Md.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W.	8. DATE OF BIRTH 3/27/1915		9. AGE (In years last birthday) 48	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Chapman				14. MOTHER'S MAIDEN NAME Hester Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Naomi Pendelton-911- Leadenhall Street		
18. 831X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Cerebral Vascular accident (stroke) DUE TO			
				(B) Hypertensive arteriosclerosis - DUE TO			
				(C) Vascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that HE (this hospital) attended the deceased from 12/31/64 19 to 1/14/65 19, that HE (we) last saw the deceased alive on 1/14/65 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Earlie H. Francis						23B. DATE SIGNED 1/14/65	
23C. PHYSICIAN'S NAME (Type) Earlie H. Francis, M.D.				23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE I-18-65		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore-City	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Isaiah L. Brown & Son		ADDRESS 108 W Montgomery St	



1
L 550

65 0744

BALTIMORE CITY HEALTH DEPARTMENT

65 0744

BIRTH NO.

63-29647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VICKY

LEMON

2. DATE AND HOUR PRONOUNCED DEAD

January 14, 1965

7:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

23-01

D. STREET ADDRESS (If rural, give location)

145 W. Hamburg Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

9. AGE (In years
last birthday)

1

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Queen Ester Lemmon 903-Bevan Street

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Congenital Heart Disease

~~Subendocardial~~ (Subendocardial Fibroelastosis)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

JAN 18 1965

23C. NAME OF CEMETERY or CREMATORY

Mount Auburn

23D. LOCATION

(City, town, or county)

Baltimore City

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Isaiah L. Brown & Son

ADDRESS

108 W. Montgomery St

WALLLEY PORCE

WALLLEY PORCE

H 534

65 0745

BALTIMORE CITY HEALTH DEPARTMENT

65 0745

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

59357

1. NAME OF DECEASED
(Type or Print)

FRANK J. HANDLIR

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965

11:23 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

915 N. Belnord Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

April 10, 1895

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

File Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Handlir

14. MOTHER'S MAIDEN NAME

Josephine Zak

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War 1

16. SOCIAL
SECURITY NO.

212-09-8077

17. INFORMANT

ADDRESS

Lottoe M. Handlir, 915 N. Belnord Av

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1- 220 65

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

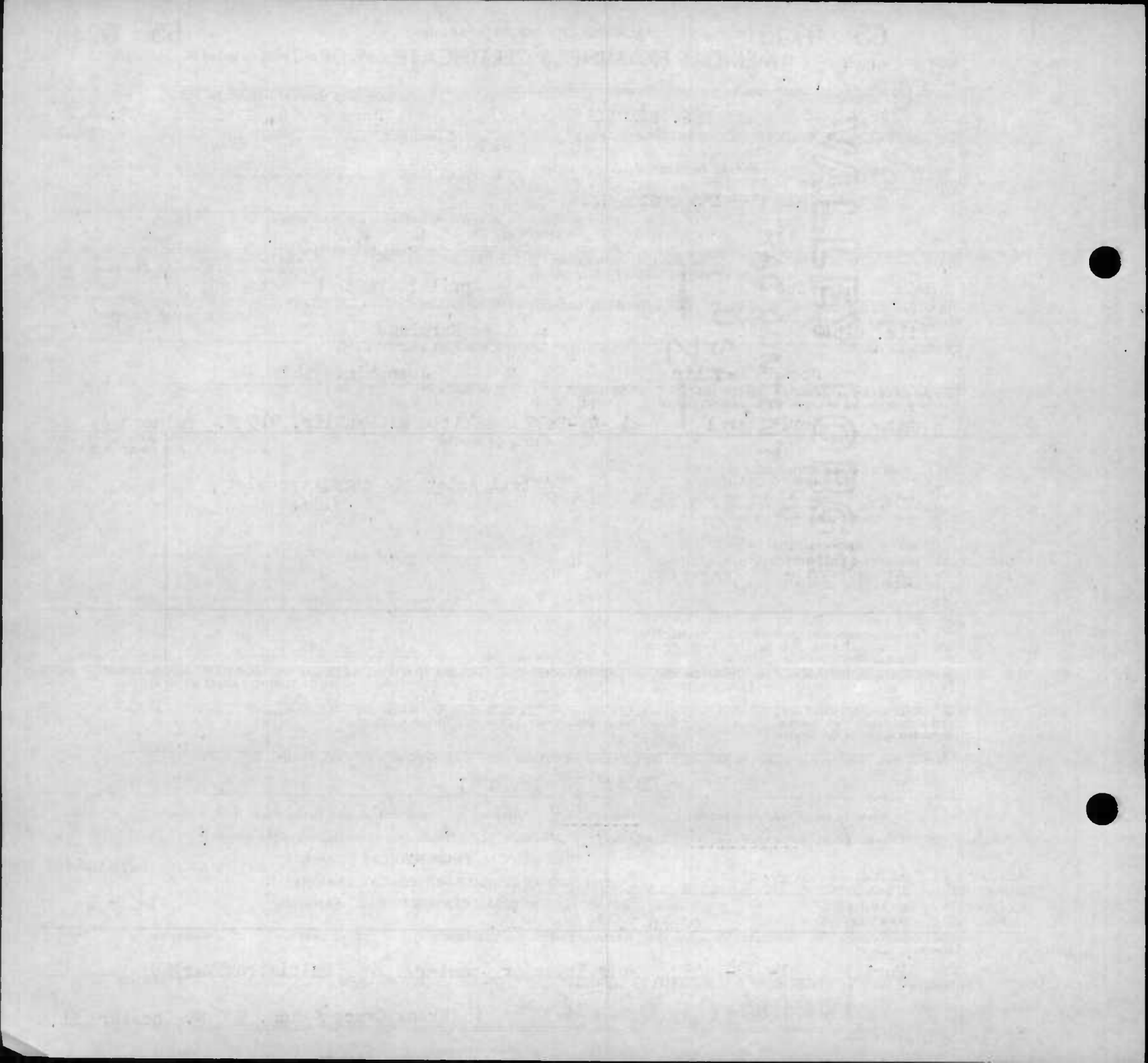
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

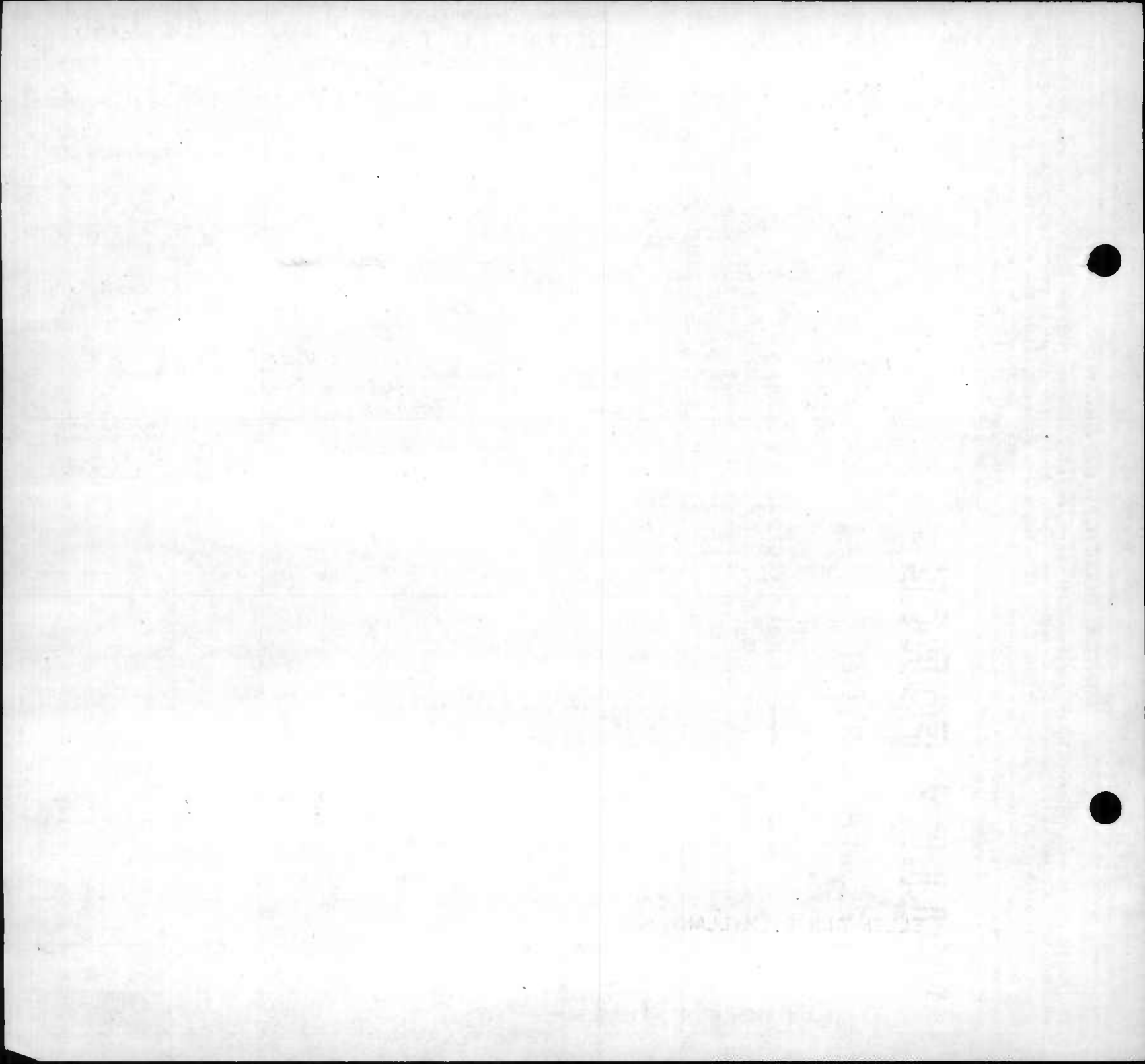
Frank Cvach & Son, 900 N. Chester St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

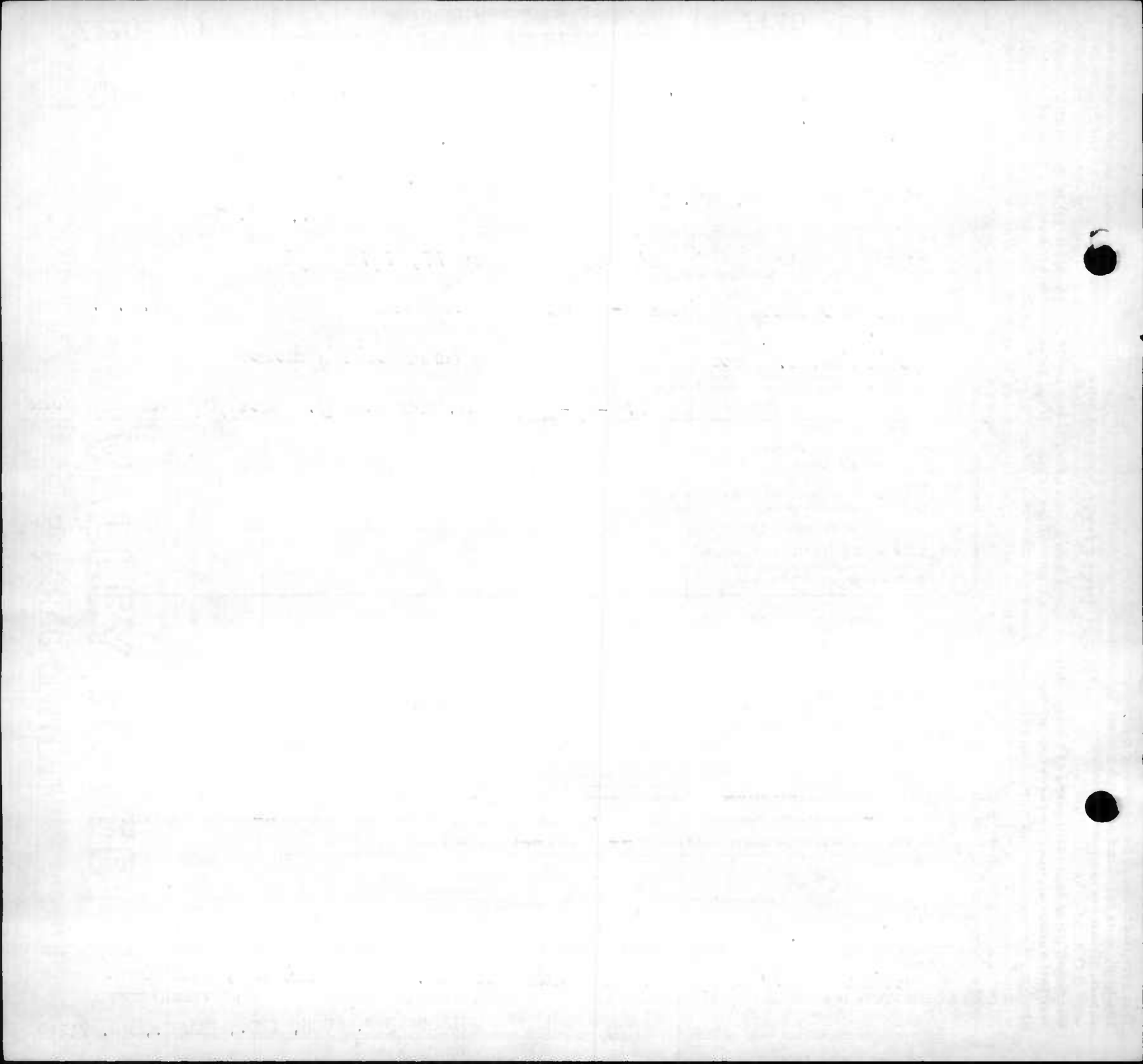
BIRTH NO. 65 0746				CERTIFICATE OF DEATH		Registered No. 65 0746	
1. NAME OF DECEASED (Type or Print) KATHERINE CAROLINE BAKER				2. DATE AND HOUR OF DEATH JANUARY 20 1965 1:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 27-34	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3621 GIBBONS AVENUE 207014			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 6-19-1891 73	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Renner				14. MOTHER'S MAIDEN NAME ANNE WANKMILLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-02-5647		17. INFORMANT MRS ANN MORRIS DAUGHTER		ADDRESS 7151 FAIRBANK RD	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Cerebral vascular accident DUE TO and (B) myocardial infarction DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 4 1965 to JAN 20 1965 , that (I) (we) last saw the deceased alive on JAN 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ellen Ann D. Millan M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan 20 1965	
23C. PHYSICIAN'S NAME (Type) ELLEN ANN D. MILLAN				23D. ADDRESS Union Memorial Hospital Balto. Md			
24A. BURIAL, CREMATION, REMOVAL (Specify) 1-23-65		24B. DATE		24C. NAME OF CEMETERY or CREMATORY PARKWOOD Cem		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 305 Hayford	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

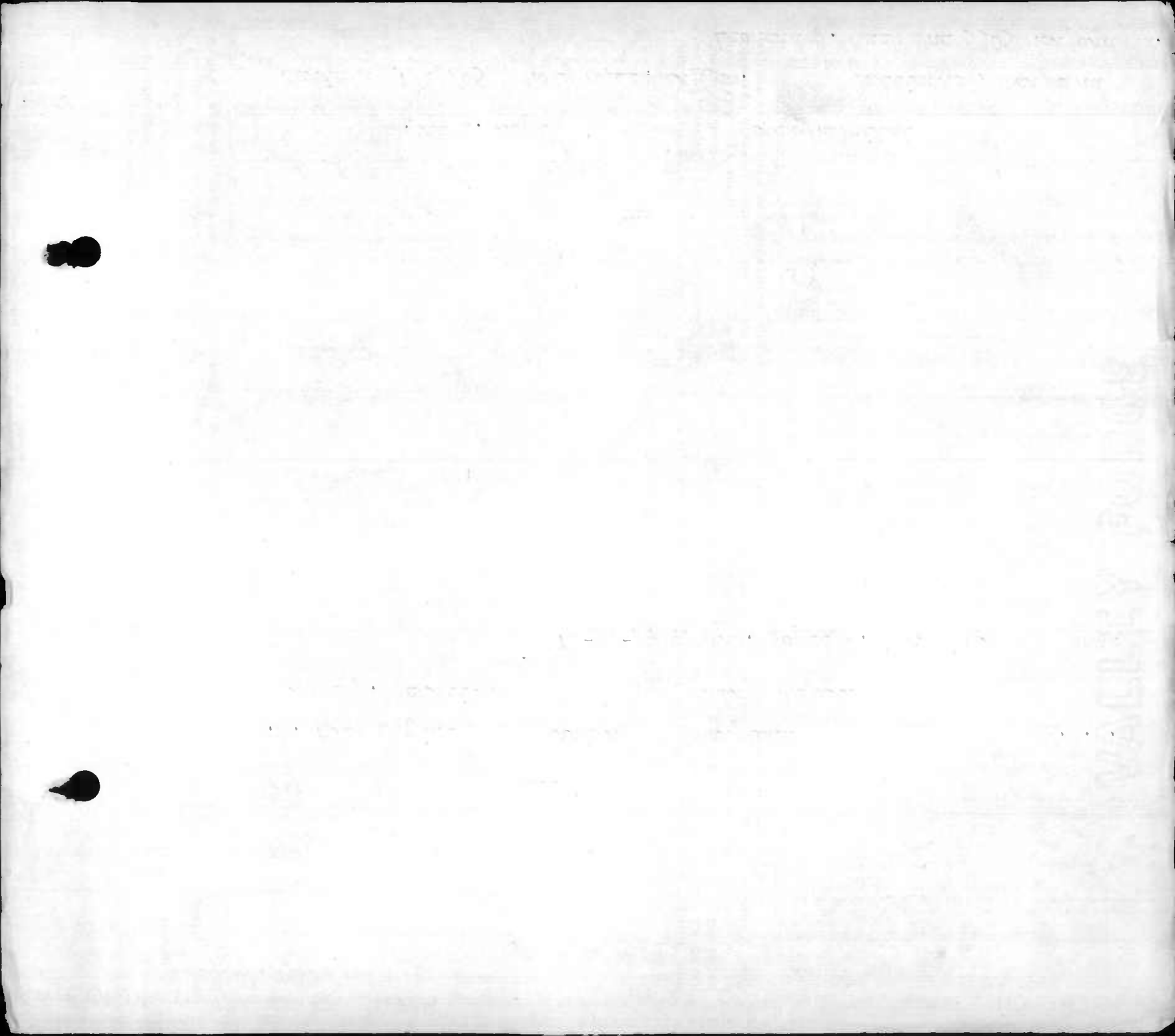
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0747</u>	
BIRTH NO. <u>65 0747</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EDITH A. SAUR</u>		2. DATE AND HOUR OF DEATH <u>Jan. 20, 1965</u> <u>12:30 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>426 WINSTON AVENUE, APT. 3</u>		A. STATE <u>MD.</u> B. COUNTY <u>27-11</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u>			
		D. STREET ADDRESS (If rural, give location) <u>426 WINSTON AVE., APT. 3</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>Nov 11, 1912</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legal Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Winter - Bowen</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Christian L. Saur</u>		14. MOTHER'S MAIDEN NAME <u>Rosemarie Maurer</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>423-03-3737</u>		17. INFORMANT ADDRESS <u>Mr. Leonard G. Saur 904 Shelley Road</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute myocardial infarction</u> DUE TO <u>10 min.</u> (B) <u>Hypertension cardiovascular</u> DUE TO <u>11 yrs.</u> disease (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 14</u> 19 <u>64</u> to <u>Jan. 20</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan. 15</u> , 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lloyd E. Saylor</u>				23B. DATE SIGNED <u>Jan. 21, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor</u>		23D. ADDRESS <u>3902 Greenmount Avenue</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holly Redeemer Cem.</u>	
		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Saylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>LEONARD J. RUCK, INC., BALTO., MD. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

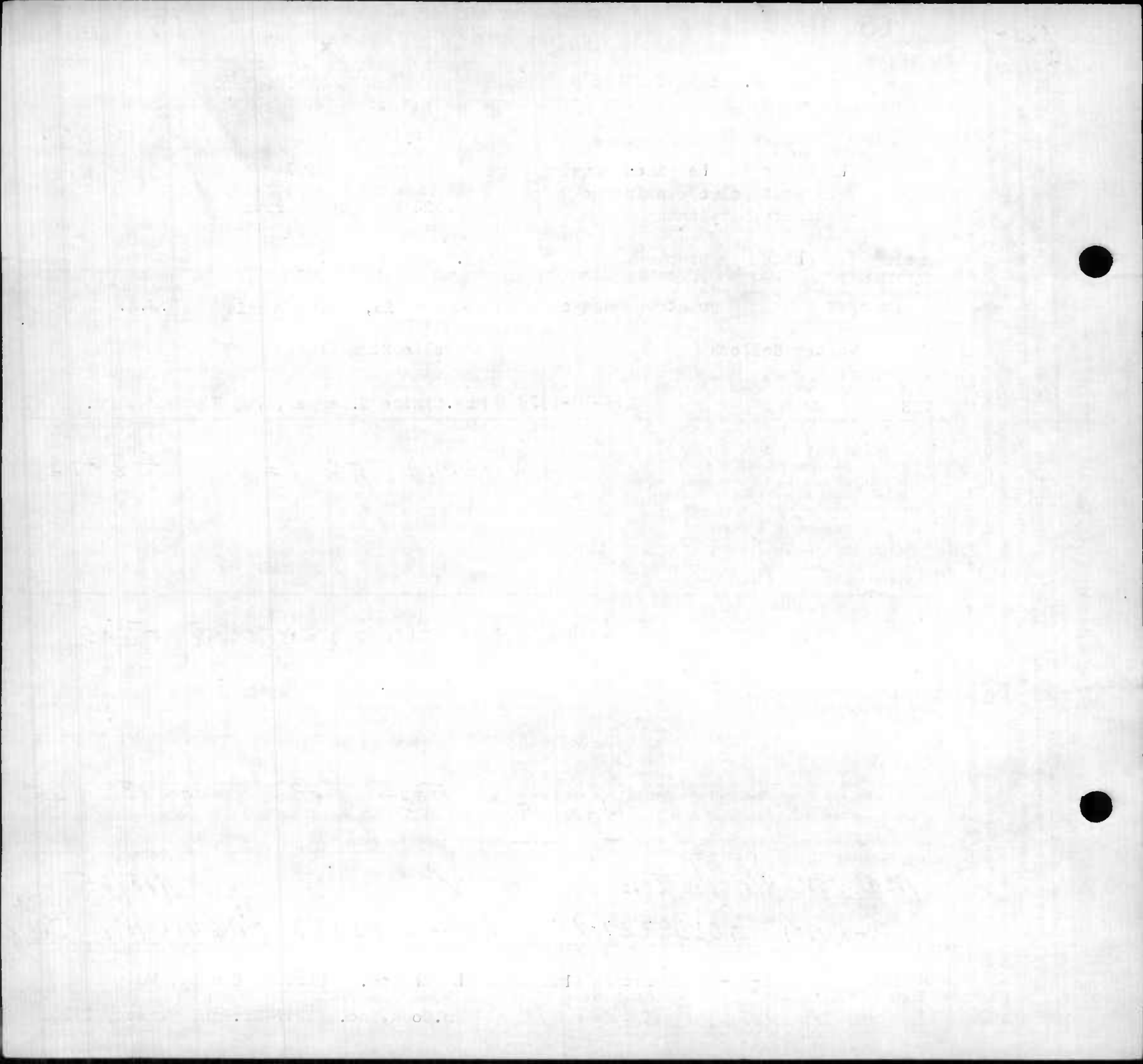
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 0748					
BIRTH NO. 65 0748		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Philip Schreiber</i>			2. DATE AND HOUR OF DEATH <i>1-21-65 6:15 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>					A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-0034</i>					
					D. STREET ADDRESS (If rural, give location) <i>3127 Kess Ave</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>12-12-36</i>	9. AGE (In years last birthday) <i>28</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Post Office</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Carrier</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Jerome J. Schreiber</i>					14. MOTHER'S MAIDEN NAME <i>Mary Meyers</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>212-34-7464</i>		17. INFORMANT <i>Mrs. Joyce M. Sabreiber</i>			ADDRESS <i>same</i>		
18. <i>190.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Increased Intra-Cranial pressure - - - marked</i> (B) <i>Cerebral Metastasis</i> (C) <i>Malignant Melanoma</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i> <i>6 mon.</i> <i>3-4 yrs.</i>		
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that the (this hospital) attended the deceased from <i>1-18</i> 19 <i>65</i> to <i>1-21</i> 19 <i>65</i> , that the (we) lost saw the deceased alive on <i>1-21</i> 19 <i>65</i> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.										
23A. SIGNATURE <i>Robert L. Doyle</i> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1-21-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Robert L. Doyle</i>						23D. ADDRESS <i>Mercy Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/23/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc 5305 Harford Rd.</i>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0749	
BIRTH NO. 65 0749		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) W. HERBERT SELLERS		2. DATE AND HOUR OF DEATH JANUARY 18, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The House In The Pines Nursing Home 2525 West Belvedere Avenue Baltimore, Maryland		A. STATE Maryland B. COUNTY Balt.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207			
		D. STREET ADDRESS (If rural, give location) 7224 Fairbrook Drive			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Jan. 6, 1891	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Downtown Garage		11. BIRTHPLACE (State or foreign country) Castle Fin, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Sellers		14. MOTHER'S MAIDEN NAME Belle Standiford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 216-10-1878		17. INFORMANT ADDRESS Mrs. Claire S. Kemper, 6705 Townbrook Dr., 21207	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 09669 I		CAUSE OF DEATH (A) VIREMIA, ACUTE DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSIVE ARTERIOSCLEROTIC CVD 5 YRS.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FALL 1963 to JAN. 18, 1965 . that (I) (we) last saw the deceased alive on JAN. 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/18/65	
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN		23D. ADDRESS 5334 LIBERTY HEIGHTS AVE. BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-21-65		24C. NAME OF CEMETERY or CREMATORY Mountain Christian Church Cem.	
24D. LOCATION (City, town, or county) (State) Harford County, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, 21202		ADDRESS			



1
J-525

65 0750

BALTIMORE CITY HEALTH DEPARTMENT

65 0750

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59352

1. NAME OF DECEASED
(Type or Print)

E.
MAYNARD JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965 7:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21221

D. STREET ADDRESS (If rural, give location)

931 Martin Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 3, 1913

9. AGE (In years last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Aircraft Worker

10B. KIND OF BUSINESS OR INDUSTRY

Martin Company

11. BIRTHPLACE (State or foreign country)

Minnesota

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest L. Johnson

14. MOTHER'S MAIDEN NAME

Alice Quarstorm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL SECURITY NO.

228-32-9436

17. INFORMANT

ADDRESS

Ruth E. Johnson, 931 Martin Rd., 21221

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

John B. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

1-22-65

23C. NAME OF CEMETERY or CREMATORY

Arlington National Cemetery

23D. LOCATION

(City, town, or county)

Arlington, Virginia

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc., 1217 St. Paul Street, 21202

WALTON FORD

R. 1512

65 0751

BALTIMORE CITY HEALTH DEPARTMENT

65 0751

BIRTH NO. 64-18707

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. Sue

1. NAME OF DECEASED (Type or Print) BABY LINDA/ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD January 18, 1965 11:30P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18

D. STREET ADDRESS (If rural, give location) 3914 W. Garrison Avenue

5. SEX Female

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH July 12, 1964

9. AGE (In years last birthday) 6

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm. Edward Robinson

14. MOTHER'S MAIDEN NAME Annetta Hinkel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Wm. E. Robinson, 3914 West Garrison Avenue

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Congenital heart disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Probable digitalis intoxication

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sinai Hospital 27-17

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 18 65 P.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Accidentally given overdose of digitalis

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

22. (Therapeutic misadventure)

ACTUAL SIGNATURE John E. Adams M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1-19-65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

23B. DATE 1-22-65

23C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery

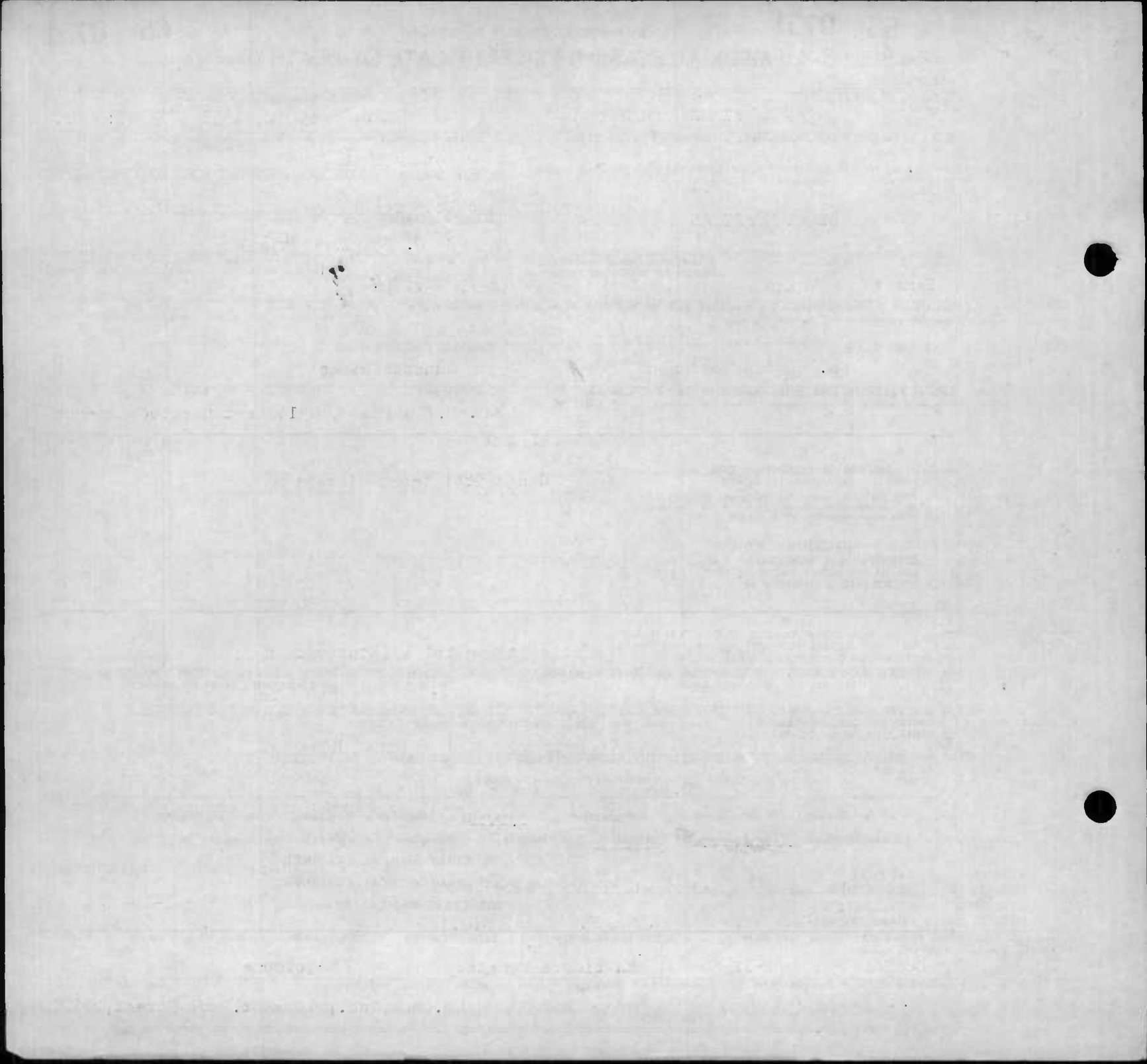
23D. LOCATION (City, town, or county) (State) Baltimore

24A. DATE REC'D BY HEALTH DEPT. JAN 21 1965

24B. NAME OF REGISTRAR Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, 21202

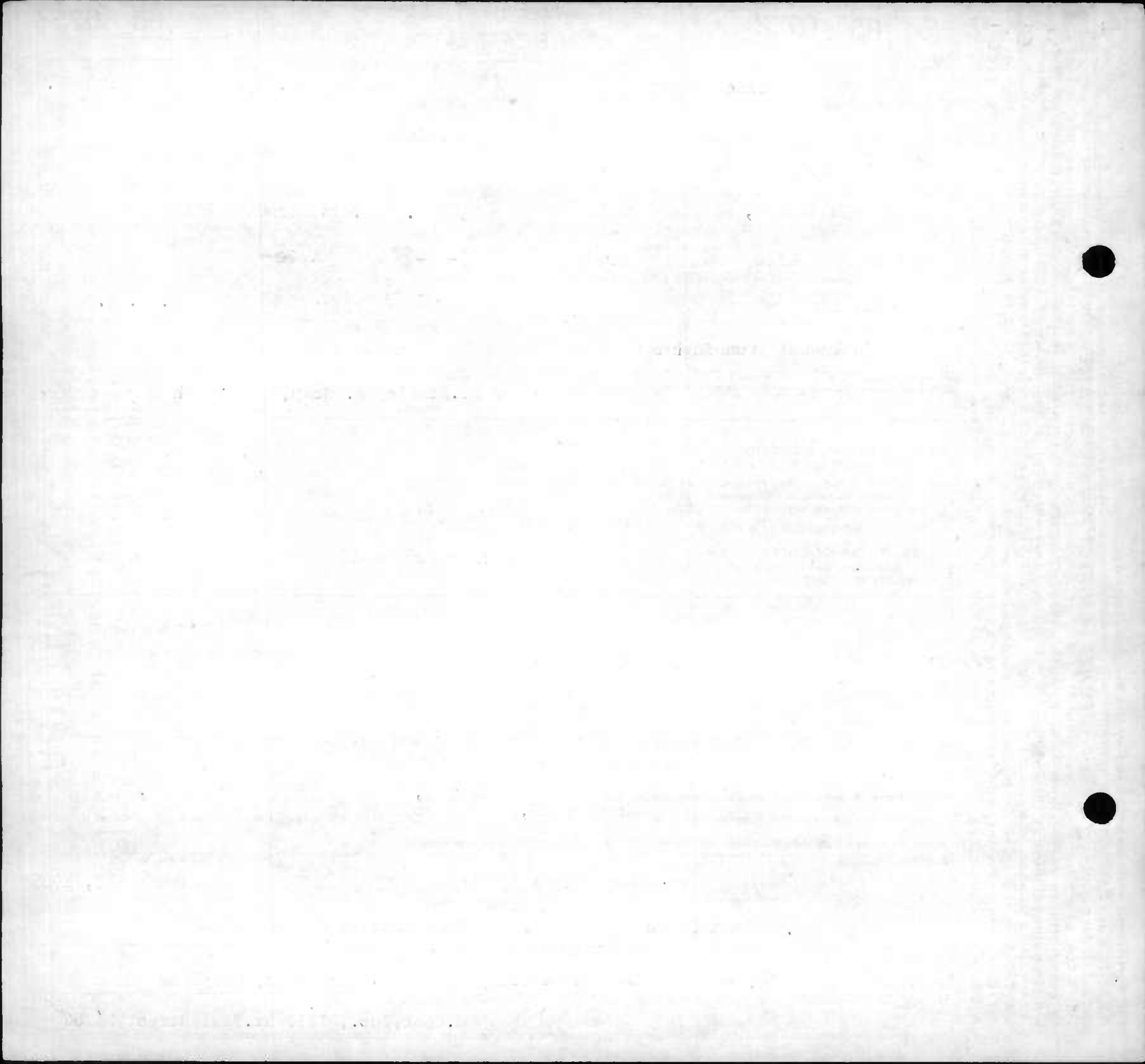
24D. ADDRESS



IS: 6-12-56-13
31
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0752	
BIRTH NO. 65 0752				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Effie Seay			January 17, 1965 8:00 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY 11-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 928 N. Calvert Street 21202		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-10-92	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME (unknown) Cunningham			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mr. Stanley A. Seay, 928 North Calvert Street RECORDS: BCH: 4940 Eastern Avenue #21224		
18. 287.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Shock (A) DUE TO Gastrointestinal Bleeding (B) DUE TO Metastatic Melanemia (C)			INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Days 3 Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 9, 1965 to January 17, 1965, that (I) (we) last saw the deceased alive on January 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Robert Cooke			23B. DATE SIGNED January 17, 1965		
23C. PHYSICIAN'S NAME (Type) C. Robert Cooke			23D. ADDRESS 4940 Eastern Avenue #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-20-65		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Woodlawn, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 21 1965		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR Wm. Cook, Inc.,		24H. ADDRESS 1217 St. Paul Street, 21202		24I. DATE	



0-625

65 0753

BALTIMORE CITY HEALTH DEPARTMENT

65 0753

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

STEVE ORGON

2. DATE AND HOUR PRONOUNCED DEAD

1-17-65

1:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

425 S. Chester Street - 21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1901

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF
WHAT COUNTRY?

Czechoslow

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-09-3452 John M. Weber Jr 401 S. Chester

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes - Partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-18-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/21/65

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery Baltimore, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

John M. Weber & Sons Inc.
401 S. Chester St.

ADDRESS

VALLEY FORD

Serial 101
John M. Warner & Son, Inc.
101 & 102
Valley Ford, N.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0755	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) TOBIN, Thomas Joseph				1/19/65 4:00 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3005 Oakhill Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/18/90	9. AGE (In years last birthday) XX 74	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Door Man		10B. KIND OF BUSINESS OR INDUSTRY Theater		11. BIRTHPLACE (State or foreign country) Kingston, New York	
13. FATHER'S NAME Thomas Tobin		14. MOTHER'S MAIDEN NAME Eliza Kerr		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/1/18-4/21/19		16. SOCIAL SECURITY NO. 212 14 0366		17. INFORMANT ADDRESS VA Hospital Records Jeanne Borsella Baltimore, Maryland 21218 3005 Oakhill Ave.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Obstructive Emphysema		Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic Bronchitis		Years	
		(C) Broncho-pneumonia, left lower lobe		3 days	
		(D) Arteriosclerotic Heart Disease		Several Years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from October 10th 19 61 to January 19th 19 65 , that (X) (we) last saw the deceased alive on January 19th 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death.					
23A. SIGNATURE Daniel C. Persyn, M.D.				23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) DANIEL C. PERSYN, M.D.		23D. ADDRESS Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. F...		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost 4600 Liberty Heights	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 0754		65 0754	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO. 65 0754		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				William Boyd Dorsey		January 17, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson's Nursing Home				A. STATE Maryland			
				B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Owings Mill			
				D. STREET ADDRESS (If rural, give location) Garrison Forest Rd.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 11, 1876	9. AGE (In years last birthday) 88	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. County Police	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edwin Dorsey				14. MOTHER'S MAIDEN NAME Anne Davis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-30-8794		17. INFORMANT Mary P. Killian-2312 Poplar Drive			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Cerebral hemorrhage (B) DUE TO Larcinoma of prostate (C) DUE TO Aneurysm of aorta - 10 yrs pulmonary infarction - 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 14 days 3 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 1-17-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostate		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1-16-65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell			
22. I certify that (I) (this hospital) attended the deceased from 1-16-65 to 1-17-65, that (I) (we) last saw the deceased alive on 1-16-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James D. Saffell				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) James D. Saffell				23D. ADDRESS Reisterstown, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1965		25B. NAME OF REGISTRAR Robert E. Jakes, M.D.		25C. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hgts. Ave			

6. 11. 1944

FUNERAL DIRECTOR: IMPORTANT

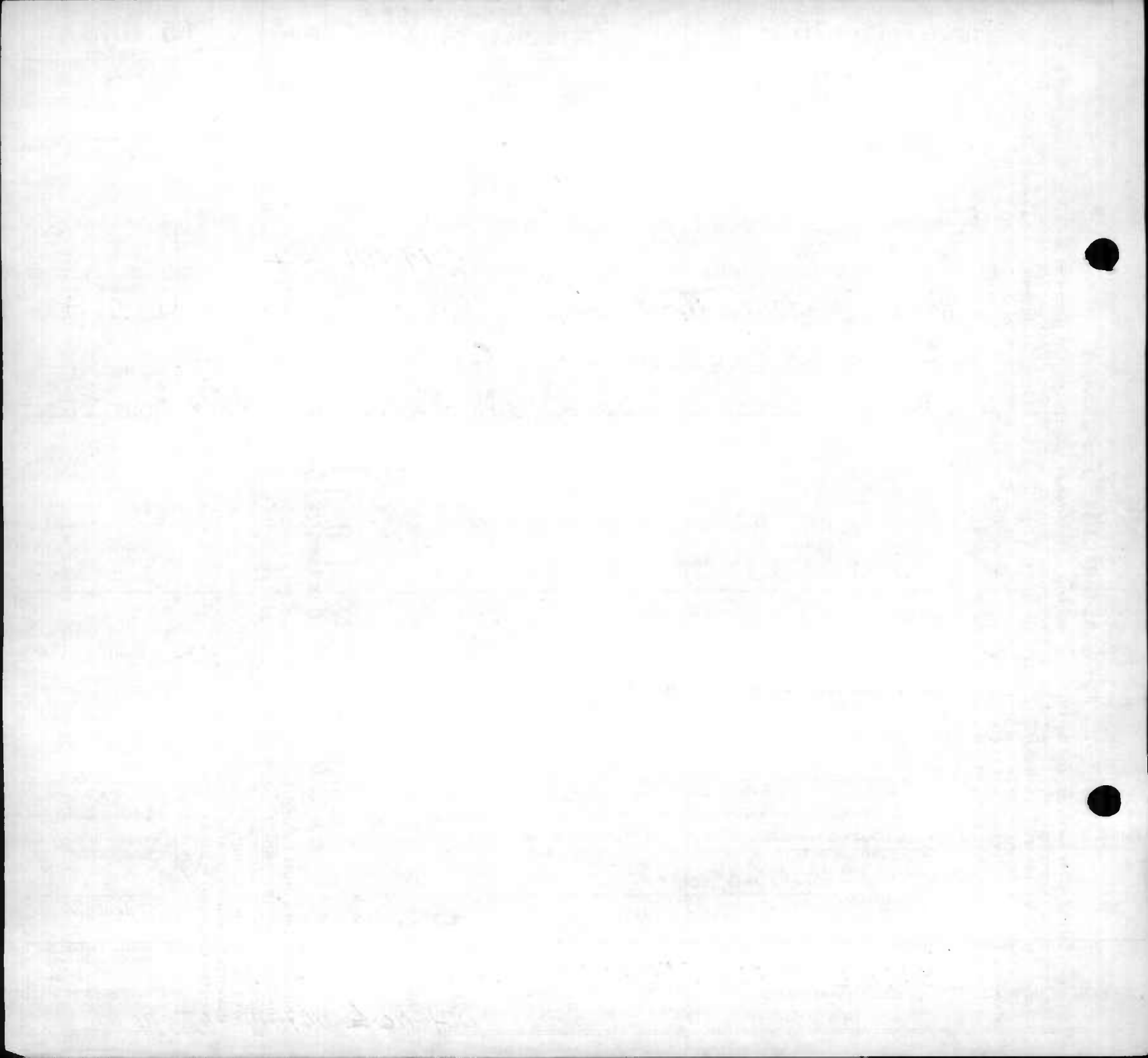
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 65 0756		Registered No. 65 0756							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE O. DRURY				2. DATE AND HOUR OF DEATH 1/21/65 3:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 18-03			
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married						8. DATE OF BIRTH 7/18/64		9. AGE (In years) 20 10. If Under 1 Yr. Months: 6 Days: 2 If Under 24 Hrs. Hours: 2 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William J. Drury						14. MOTHER'S MAIDEN NAME Betty Ball			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. William J. Drury		ADDRESS Above			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Undetermined Hc expiration. 2 days.						(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO Bronchopneumonia			
						(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from Jan 20 19 65 to Jan 21 19 65 , that the (we) last saw the deceased alive on Jan 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. It (We) did (did not) view the body after death.									
23A. SIGNATURE Albert M. Gordon M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 1/21/65			
23C. PHYSICIAN'S NAME (Type) ALBERT M. GORDON M.D.						23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cem.		24D. LOCATION (City, town, or county) Baltimore (State) md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc.		ADDRESS 901 Hollins St. 23, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 0757</u>				
BIRTH NO. <u>65 0757</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>SWEARENGIN, TOLBERT</u>					2. DATE AND HOUR OF DEATH <u>1-20-65</u> <u>1:20 P.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME AND HOSPITAL</u>					A. STATE <u>MD</u>				
					B. COUNTY <u>202</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>1830 E PRATT ST</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 17-1911</u>		9. AGE (In years last birthday) <u>54</u>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>MC COCKRIE</u>		11. BIRTHPLACE (State or foreign country) <u>MILLBORO VA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES SWEARENGIN</u>					14. MOTHER'S MAIDEN NAME <u>CORA LEE SMITH</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>226-12-3743</u>		17. INFORMANT <u>MAUDE SWEARENGIN</u> ADDRESS <u>1830 E PRATT STREET</u>				
18. <u>4 2011 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <u>Cardiac arrest</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		
					(B) <u>Acute myocardial infarction</u> DUE TO		<u>hours</u>		
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-20 12:45 PM</u> 19 <u>65</u> to <u>1-20 1:20 PM</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> 19 <u>65</u> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Jose S. Maisog M.D.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1-20-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSE S. MAISOG</u>					23D. ADDRESS <u>CHURCH HOME AND HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>JAN 24 65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>REHOBETH CEM.</u>			24D. LOCATION (City, town, or county) (State) <u>MILLBORO VA.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>			25C. FUNERAL DIRECTOR <u>D.H. McLAUGHIN</u>			ADDRESS <u>HOTSPRINGS VA</u>	



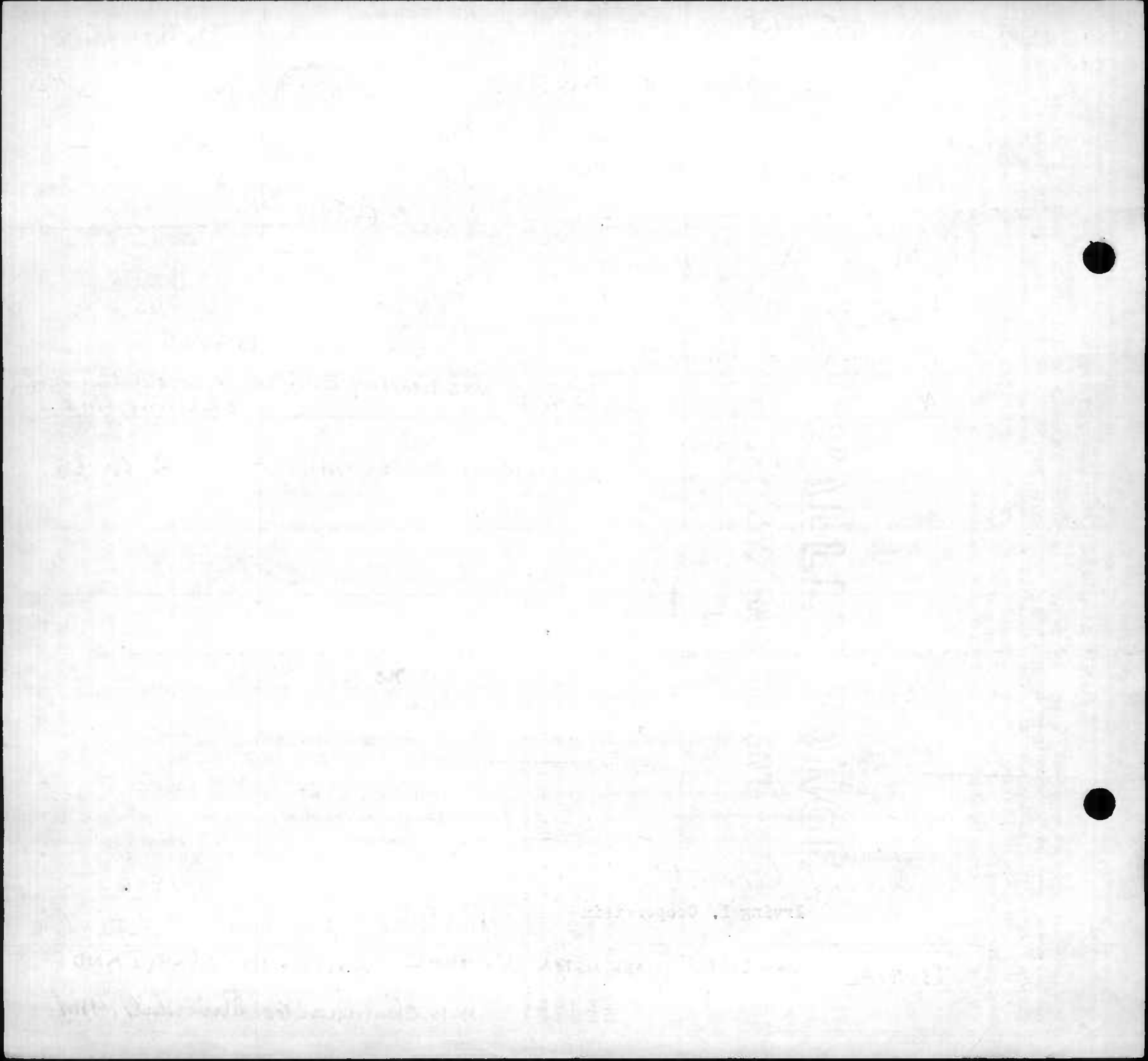
K-6131

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																	
BIRTH NO. 65 0758					CERTIFICATE OF DEATH					Registered No. 65 0758							
M.E. CASE NO.										2. DATE AND HOUR OF DEATH							
1. NAME OF DECEASED (Type or Print) GEORGE E. KRAFT										JAN. 19 1965 2 ²⁰ A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSPITAL										A. STATE MD.							
(If not in hospital or institution, give street address or location)										B. COUNTY 11-03							
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.							
										D. STREET ADDRESS (If rural, give location) 831 N. EUTAW ST.							
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 10-30-1877		9. AGE (In years last birthday) 87		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE GROOM				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) PENNA.				12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME NORMAN A. KRAFT						14. MOTHER'S MAIDEN NAME ? LAURA DAVIS											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. 212-18-4696		17. INFORMANT MRS DOROTHY E. GREEN ADDRESS 1510 Chillum Rd. Chillum, Md.									
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) BRONCHO PNEUMONIA										CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) DUE TO				(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?									
22. I certify that (H) (this hospital) attended the deceased from 12-17 19 64 to 1-19 19 65 , that (H) (we) last saw the deceased alive on 1-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.																	
23A. SIGNATURE Irving L. Cooperstein										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1-19-65			
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein										23D. ADDRESS Montebello STATE HOSP., BALTO., MD.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE JAN 21, 1965		24C. NAME OF CEMETERY or CREMATORY WASHINGTON NATIONAL				24D. LOCATION (City, town, or county) (State) SUITLAND MARYLAND							
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965				25B. NAME OF REGISTRAR Robert E. Farley, M.D.				25C. FUNERAL DIRECTOR W. W. Chamberlin Co. Riverdale, Md.				ADDRESS					



SAB-41-14-26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0759

BIRTH NO. 65 0759

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Karol Koziol (KOZUL)

2. DATE AND HOUR OF DEATH

1-18-1965

7 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals,
4940 Eastern Avenue,
Baltimore, Maryland-212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

224 South Maderia Street, 21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

7-1-1891

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

18. 13 IX I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATHMetastatic Carcinoma of the
Stomach(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

same

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-15-19 65 to 1-18-19 65,
that (I) (we) last saw the deceased alive on 1-18-19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Robert Cooke

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

1-18-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Robert Cooke

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-22-65

24C. NAME OF CEMETERY or CREMATORY

Holy Trinity

24D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 22 1965

25B. NAME OF REGISTRAR

Robert E. Jankowski

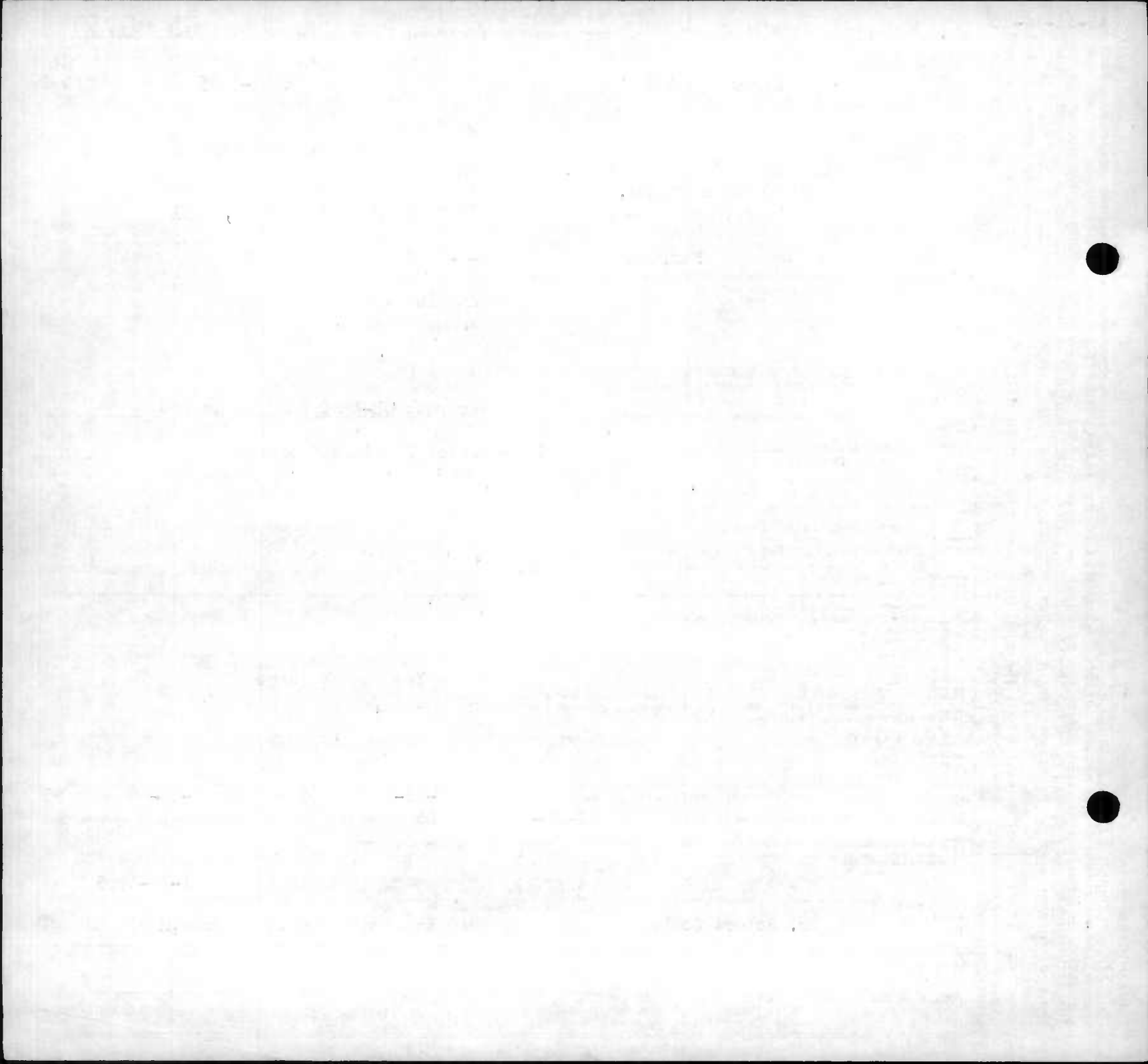
25C. FUNERAL DIRECTOR

FRED OZARIEWSKI - 1930 EASTERN AVE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

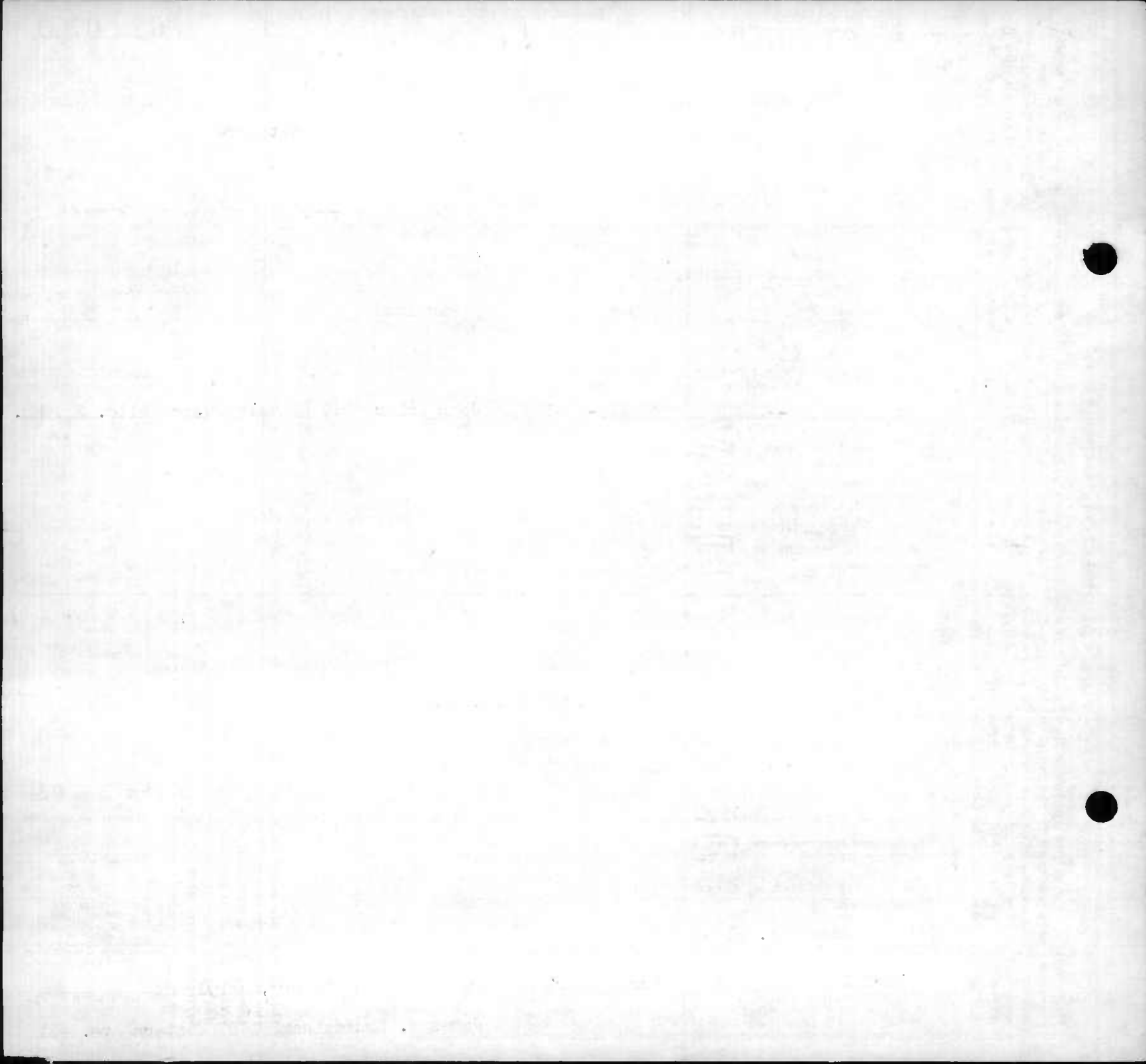
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

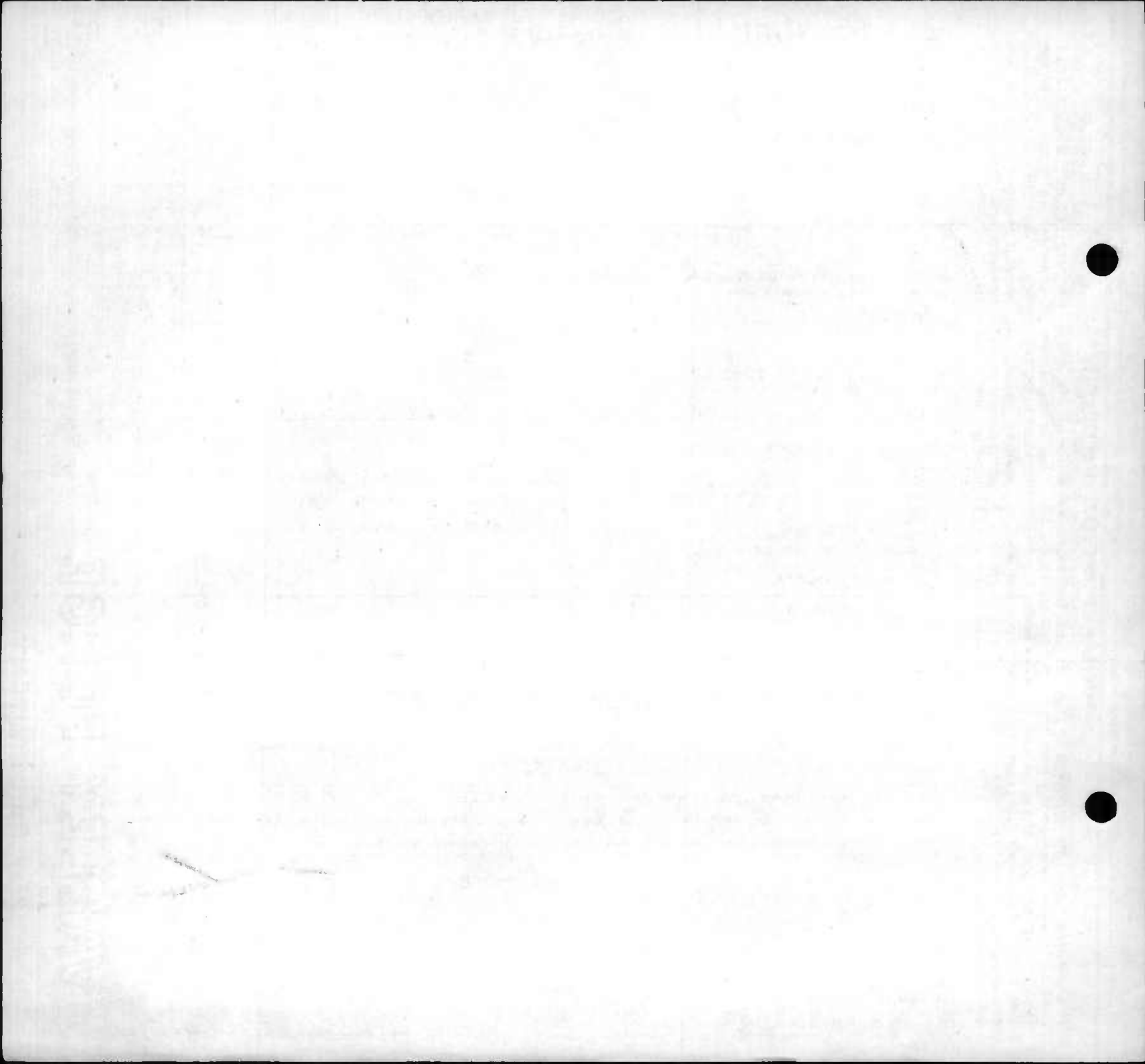
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0760	
BIRTH NO. 65 0760		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Esler, Mrs. Julia		2. DATE AND HOUR OF DEATH 1-20-65 9:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hospital				A. STATE Md. B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (61 53-00			
				D. STREET ADDRESS (If rural, give location) 1911 Ellenwood Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 6-10-01	9. AGE (In years last birthday) 63	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland
				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Bernard Kruszeowski				14. MOTHER'S MAIDEN NAME Lena Wozniak			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --				16. SOCIAL SECURITY NO. 215-03-1838D			
				17. INFORMANT John Esler 6920 Delvale Place Balto. 22, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Sarcoma of uterus DUE TO (B) Lung's metastases DUE TO (C)			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-27-1964 to 1-20-1965, that (I) (we) last saw the deceased alive on 1-20-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph E. Blanton				23B. DATE SIGNED 1-20-65			
23C. PHYSICIAN'S NAME (Type) Joseph E. Blanton				23D. ADDRESS Church Home Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary		24D. LOCATION (City, town, or county) Baltimore, Maryland (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR James E. Bruzdziński		ADDRESS 1407 Eastern Ave. #21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

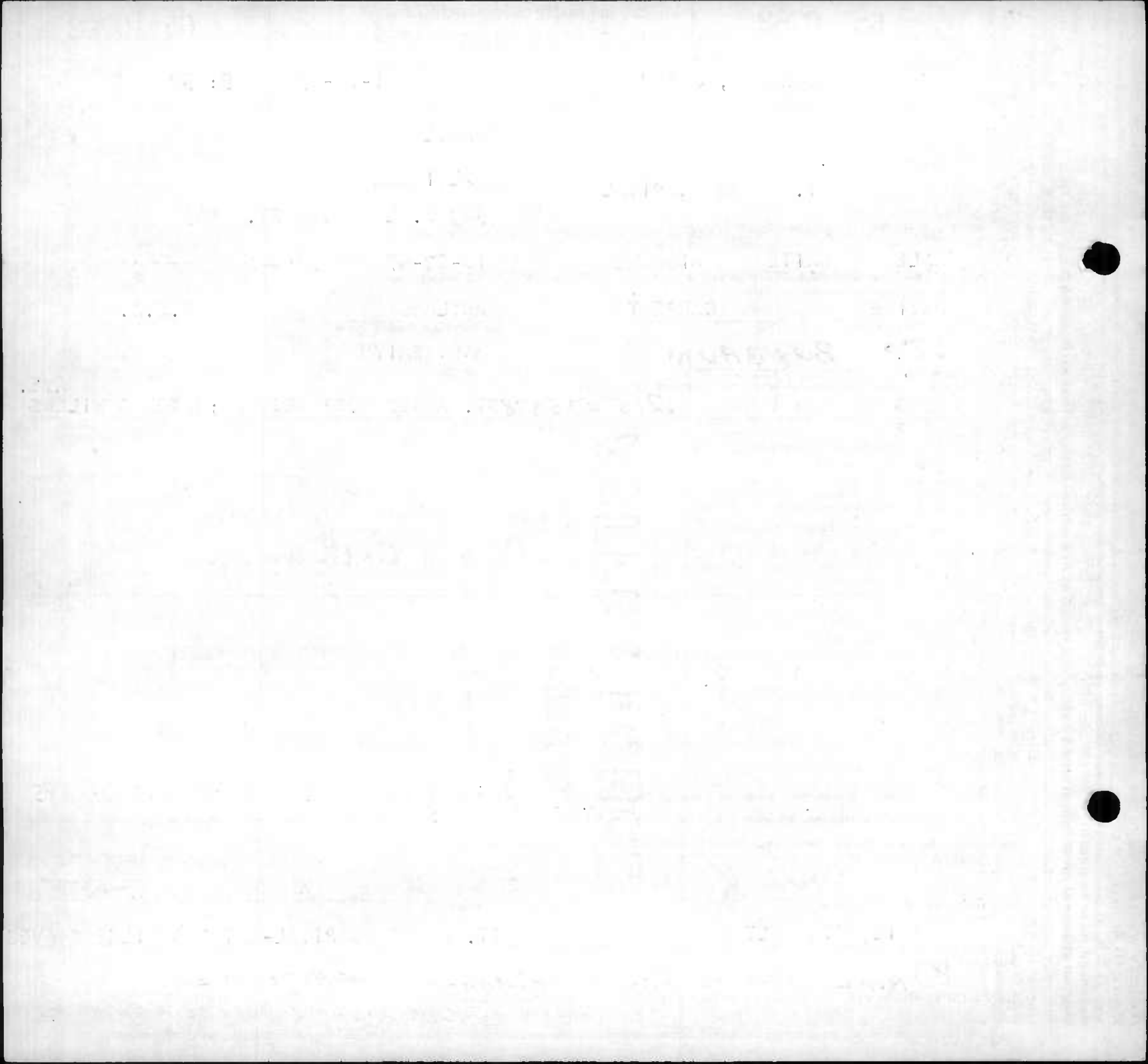
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0761				
BIRTH NO. 65 0761					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>HILDA LEWIN</u>					2. DATE AND HOUR OF DEATH <u>JAN 20, 1965</u> <u>112</u> <u>W.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>515 NASSAU ST</u>					A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Belts.</u> D. STREET ADDRESS (If rural, give location) <u>515 NASSAU ST.</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4-25-1915</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ALFRED REIFENBERG</u>					14. MOTHER'S MAIDEN NAME <u>FREDIEKE ROSENBLAT</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT ADDRESS <u>ERNEST LEWIN 515 NASSAU ST</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple Sclerosis</u> <u>Brain aneurysm ruptured.</u> <u>Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>about 1958</u> to <u>Jan 20, 1965</u> , that (I) (we) last saw the deceased alive on <u>Jan 20, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Paul P. Hamburger Jr.</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>Jan 20, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Paul P. Hamburger Jr.</u>					23D. ADDRESS <u>1005 St. Paul St Baltimore 12 Md</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-21-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHESTER A. HAVAS CHESD</u>		24D. LOCATION (City, town, or county) (State) <u>BALDWINSTOWN MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Jack Lewis Inc 2100 E. Main Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

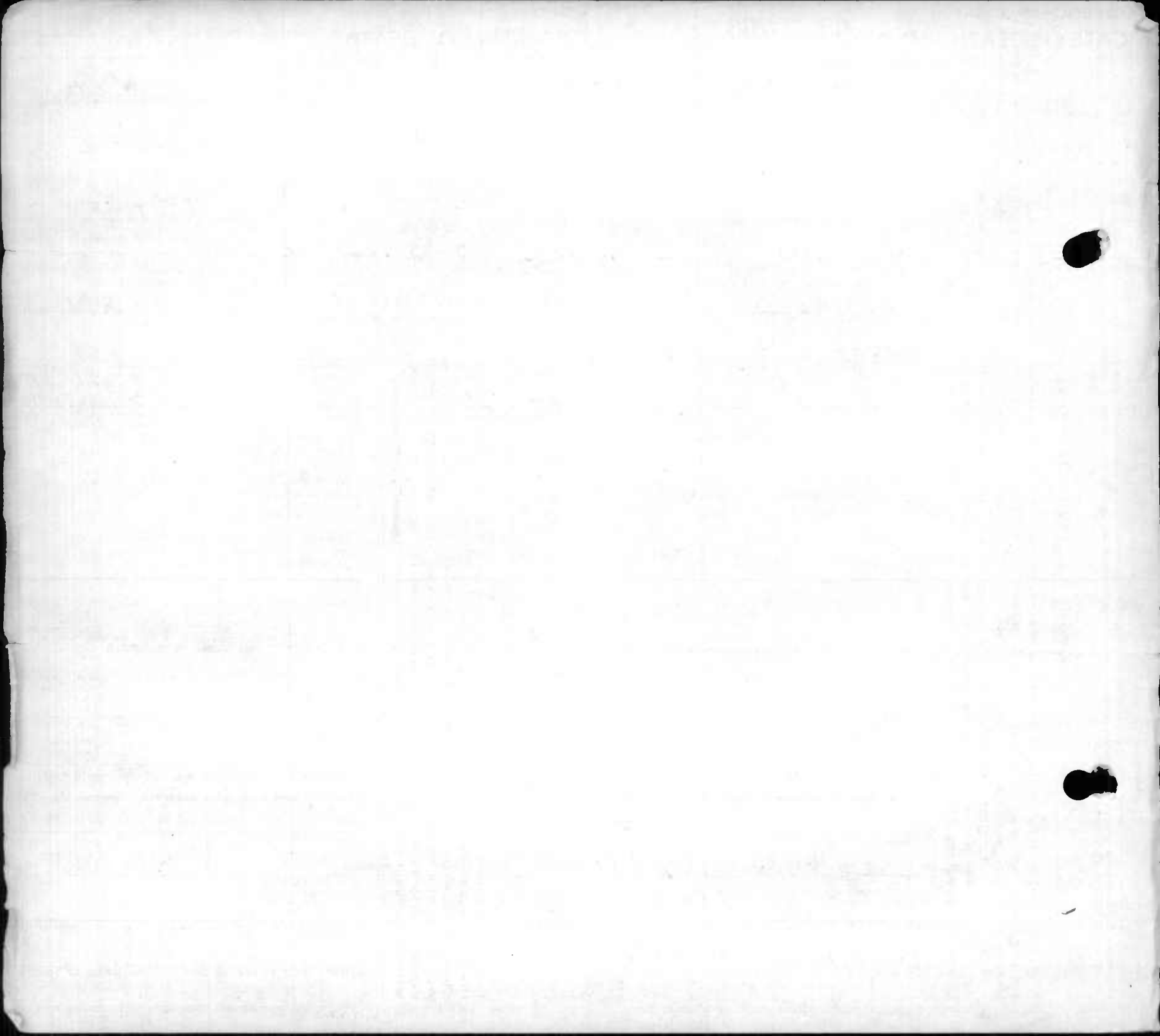
BIRTH NO. 65 0762		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0762	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		BUXBAUM, JOSEPH		2. DATE AND HOUR OF DEATH 1-19-65 5:15P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		2006	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
ST. AGNES HOSPITAL		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
		549 S. LONGWOOD ST. #23			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-12-87	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CARPENTER	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH BUXBAUM		14. MOTHER'S MAIDEN NAME MARY SMITH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WAR 1		16. SOCIAL SECURITY NO. 215-075878		17. INFORMANT ST. AGNES HOSP RECORDS; CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 751X I SHOCK Lower nephroses nephrosis Ruptured Aortic Aneurysm		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 18 19 65 to JANUARY 19 19 65, that (I) (we) lost saw the deceased alive on JANUARY 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edilberto R. Beltran		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-19-65	
23C. PHYSICIAN'S NAME (Type) EDILBERTO BELTRAN		23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/22/65		24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	
24D. LOCATION BALTO. MD.		24E. NAME OF REGISTRAR E. S. MACNABB		24F. FUNERAL DIRECTOR 301 FREDERICK RD	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR E. S. MACNABB		25C. FUNERAL DIRECTOR 301 FREDERICK RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

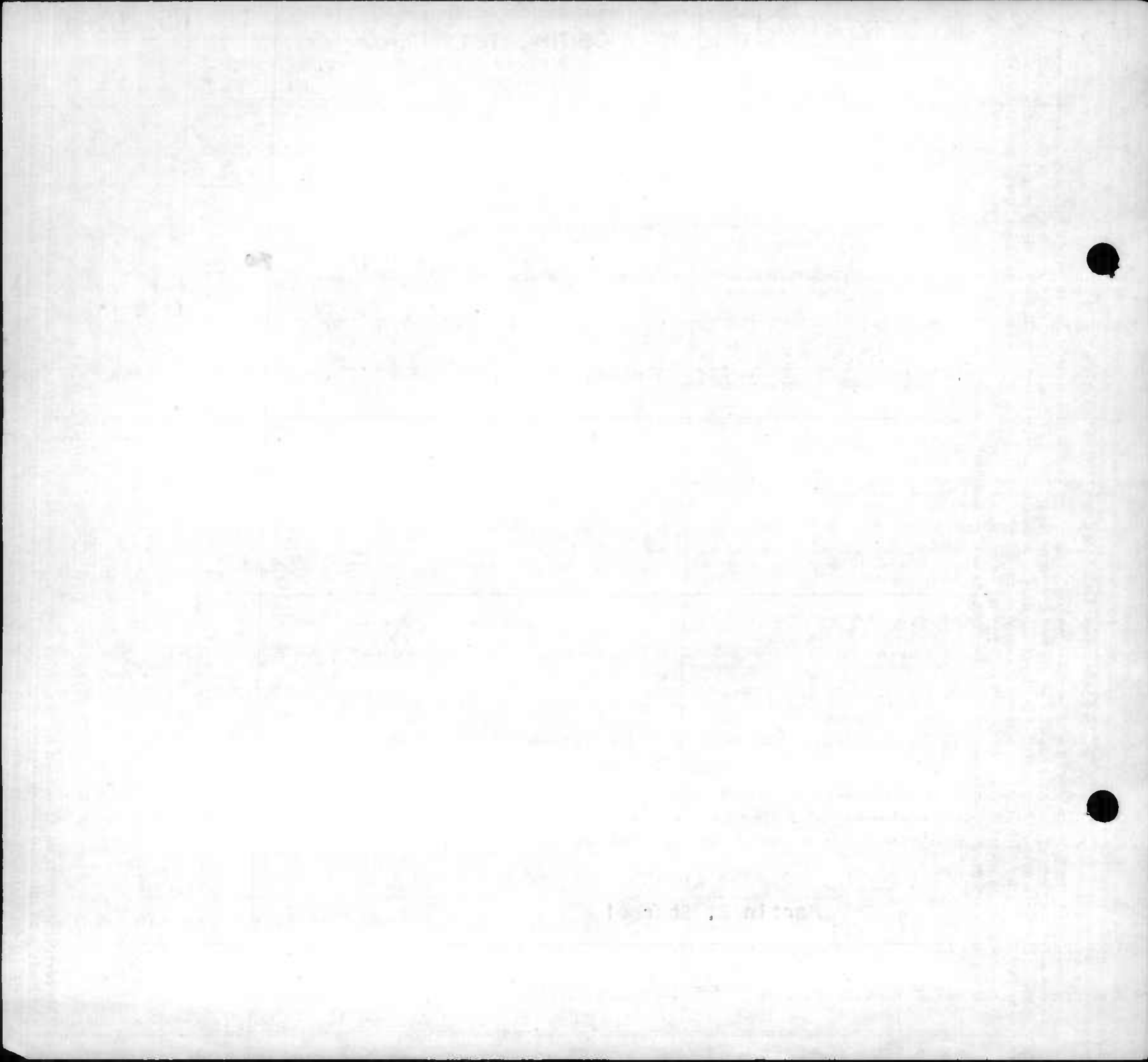
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0763					CERTIFICATE OF DEATH					Registered No. 65 0763				
M.E. CASE NO.										2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) WILSON HEINTZMAN										1/30/65 125 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSP.										A. STATE MARYLAND				
(If not in hospital) or institution, give street address or location										B. COUNTY 27-16				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO				
										D. STREET ADDRESS (If rural, give location) 4733 PARK HEIGHTS AVE.				
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-12-1899		9. AGE (In years last birthday) 65		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY Humble Oil				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Heintzman						14. MOTHER'S MAIDEN NAME Mary King								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. 212-09-0150		17. INFORMANT Mr. Wilson C. Heintzman				ADDRESS 106 Phebe Ave		
18. 5271 I						CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH NO		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						(A) CHRONIC LUNG DISEASE DUE TO Emphysema & Atherosclerosis Heart disease						YEARS		
ANTECEDENT CAUSES						(B) DUE TO								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) DUE TO								
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that he (this hospital) attended the deceased from 12/24 1964 to 1/30 1965 , that he (we) last saw the deceased alive on 1/19 1965 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.														
23A. SIGNATURE Salvatore R. Donohue M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/30/65		
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE M.D.										23D. ADDRESS MERCY HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge				24D. LOCATION (City, town, or county) (State) Baltimore Md				
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965				25B. NAME OF REGISTRAR Robert E. Farley M.D.				25C. FUNERAL DIRECTOR Forcing Byers				ADDRESS 2728 Liberty Rd. Randalltown		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0764	
BIRTH NO. 65 0764		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH JAN. 19, 1965 12:35 P.M.			
1. NAME OF DECEASED (Type or Print) JACK KEYS		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 18-01			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE, MD-21201		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 871 W. FAYETTE ST. D. STREET ADDRESS (If rural, give location) BALTIMORE, MD.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH FEB. 2, 1894	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Keys		14. MOTHER'S MAIDEN NAME Betty Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 392X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Uremia Chronic renal disease		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN. 17 1965 to JAN. 19 1965 , that (I) (we) last saw the deceased alive on JAN 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Martin C. Shargel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL		23D. ADDRESS M.D. UNIVERSITY OF MD. HOSPITAL, BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME of CEMETERY or CREMATORY W. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Carroll-2400 Lakeside Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0765	
BIRTH NO. 65 0765		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALLER, PEYTON		2. DATE AND HOUR OF DEATH 20 JAN 1965 - 4:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 5-01			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 306 N. EDEN ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 3-15-83		9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery - Pastry		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MILLSBORO, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS WALLER				14. MOTHER'S MAIDEN NAME ANNIE ROSS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-3143		17. INFORMANT Agnes BEANS		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASHD, Emphysema				CAUSE OF DEATH (A) CARCINOMA OF PROSTATE DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 mon.	
				(B) DUE TO			
				(C) DUE TO			
19A. DATE OF OPERATION 2 Nov				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 30 1964 to Jan 20 1965 , that (I) (we) last saw the deceased alive on Jan 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. N. RIFFLE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) G. N. RIFFLE				23D. ADDRESS M.D. 601 N. BROADWAY BALTIMORE 5 MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-65		24C. NAME OF CEMETERY or CREMATORY Old John, Cem.		24D. LOCATION (City, town, or county) (State) Kilmoruck, VA.	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Campbell Funeral Home		ADDRESS Kilmoruck, VA.	

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

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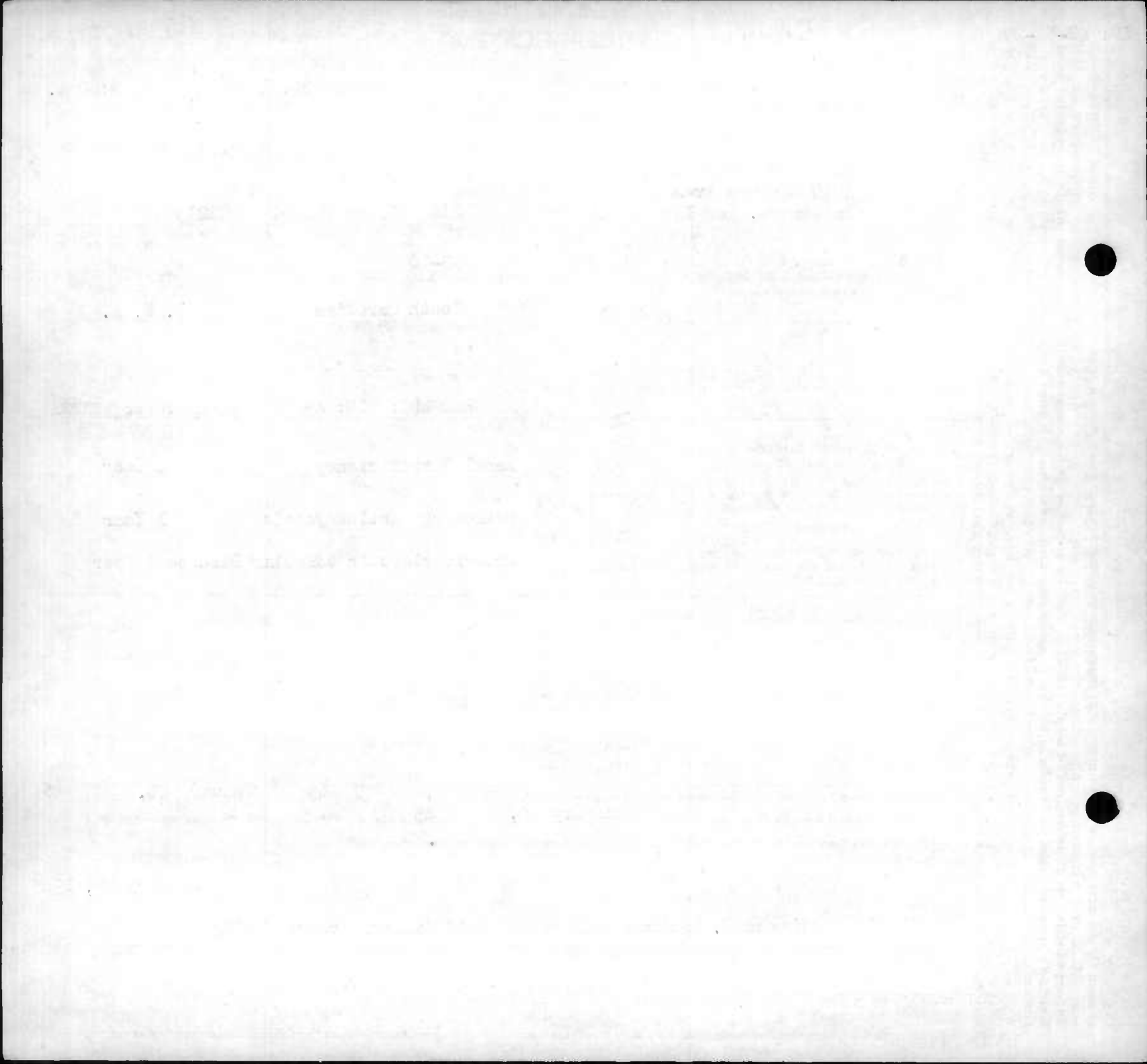
LS: 42-5429

31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

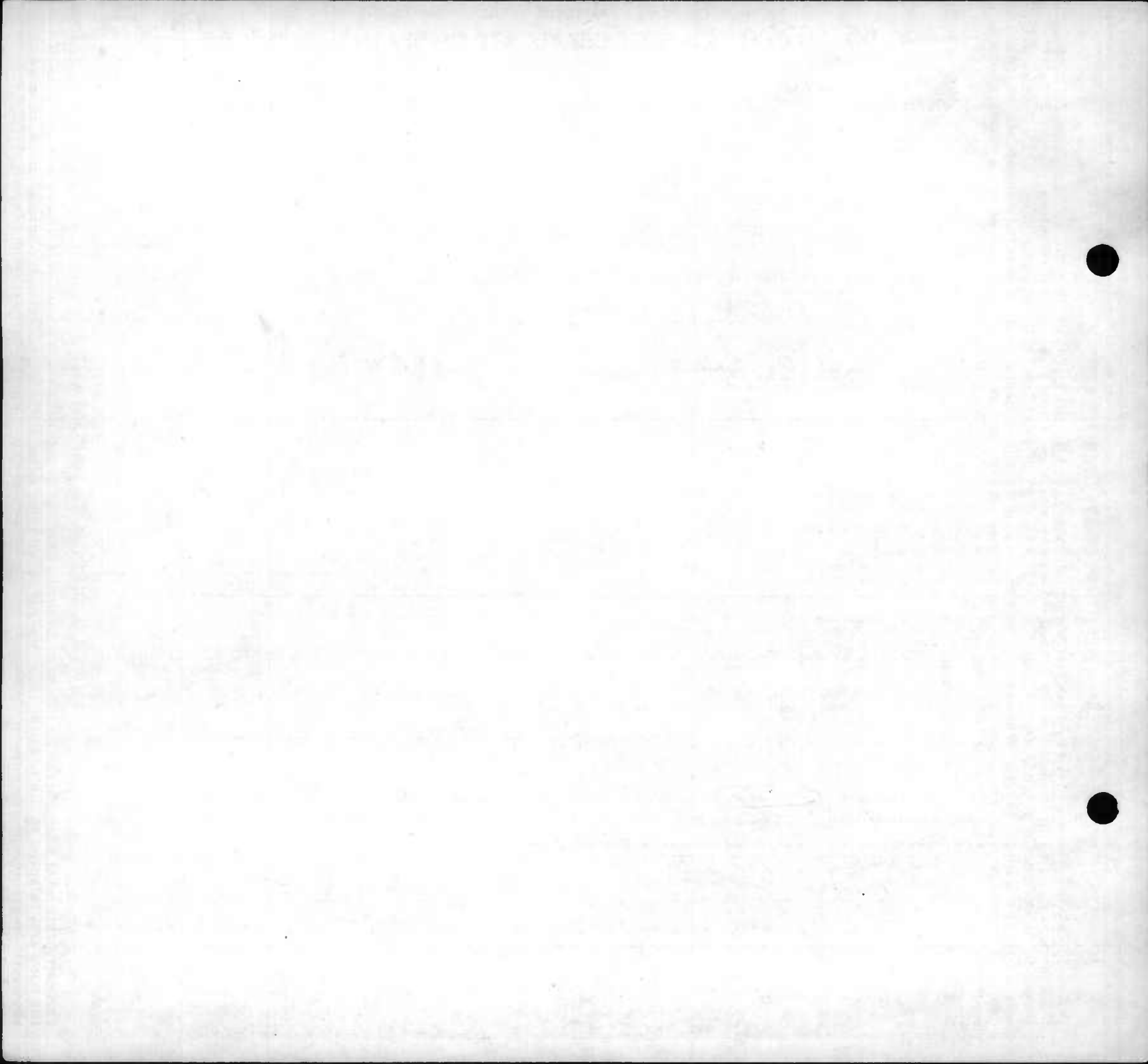
BIRTH NO. 65 0766		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0766	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Elijah Goines				January 20, 1965 8:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY 9-08			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2214 Aikens Street #21213			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-3-00	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Goines				14. MOTHER'S MAIDEN NAME Rebecca Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-6502		17. INFORMANT RECORDS: BCH: 4940 Eastern Avenue #21224			
18. 132X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Renal Insufficiency 1 Year				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Actinomycosis 1 Year							
				Arteriosclerotic Vascular Disease 1 Year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 7, 1965 to January 20, 1965 , that (I) (we) last saw the deceased alive on January 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Howard K. Rathbun				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 20, 1965	
23C. PHYSICIAN'S NAME (Type) Howard K. Rathbun				23D. ADDRESS M.D. 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/65		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR E. O. Wilson		ADDRESS 1000 Brantley Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0767	
BIRTH NO. 65 0767		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) JAMES SPIVEY			2. DATE AND HOUR OF DEATH JAN. 20, 1965 308 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL BALTO 1, MD			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 221 N. FREMONT AVE (1)		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 3/18/1880	9. AGE (In years last birthday) 84	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Jesuit VA	
13. FATHER'S NAME Oliver Spivey			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-364		17. INFORMANT Nannie Spivey	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH ?			19. CAUSE OF DEATH (A) DUE TO ACUTE PULMONARY EDEMA (B) DUE TO ARTERIOCLEROTIC HEART DISEASE? (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Jan 20 1965 to Jan 20 1965, that (I) (we) last saw the deceased alive on Jan 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Martin C. Shargel				23B. DATE SIGNED Jan. 20, 1965	
23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL				23D. ADDRESS University of Md. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/1965		24C. NAME OF CEMETERY or CREMATORY Mt Carmel	
24D. LOCATION Balto Md		24E. CITY, TOWN, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Choy C. Wilson 1000 Beauty Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0768

BIRTH NO. 65 0768

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

RAYMOND COOK

2. DATE AND HOUR OF DEATH

JAN 20, 1965 9 50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

HOUSE IN THE PINES
2525 W BELVEDERE AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MD

1305

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

716 PURITAN ST.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

AUG. 11-1891

9. AGE (In years last birthday)

73

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

DEPT. STORE

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

MARSHALL COOK

14. MOTHER'S MAIDEN NAME

FLORENCE DOVE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

215-10-5879

17. INFORMANT

Mrs VIRGINIA COLLIGON-ELLICOTT CITY ADDRESS
9 MARYDELL RD MD

18.

422.N-260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Arteriosclerotic Cardiovascular Disease

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

1) Diabetes Mellitus 2) Rheumatoid Arthritis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 19 65 to JAN 20 19 65, that (I) (we) last saw the deceased alive on JAN 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Sheldon Goldgeier

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

JAN 20, 1965

23C. PHYSICIAN'S NAME (Type)

Sheldon Goldgeier

23D. ADDRESS

M.D.

848 W 36th Street Baltimore MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-23-65

24C. NAME OF CEMETERY or CREMATORY

Lanham

24D. LOCATION (City, town, or county) (State)

Baltimore MD 36th St. 814 W 36th

25A. DATE REC'D BY HEALTH DEPT.

JAN 22 1965

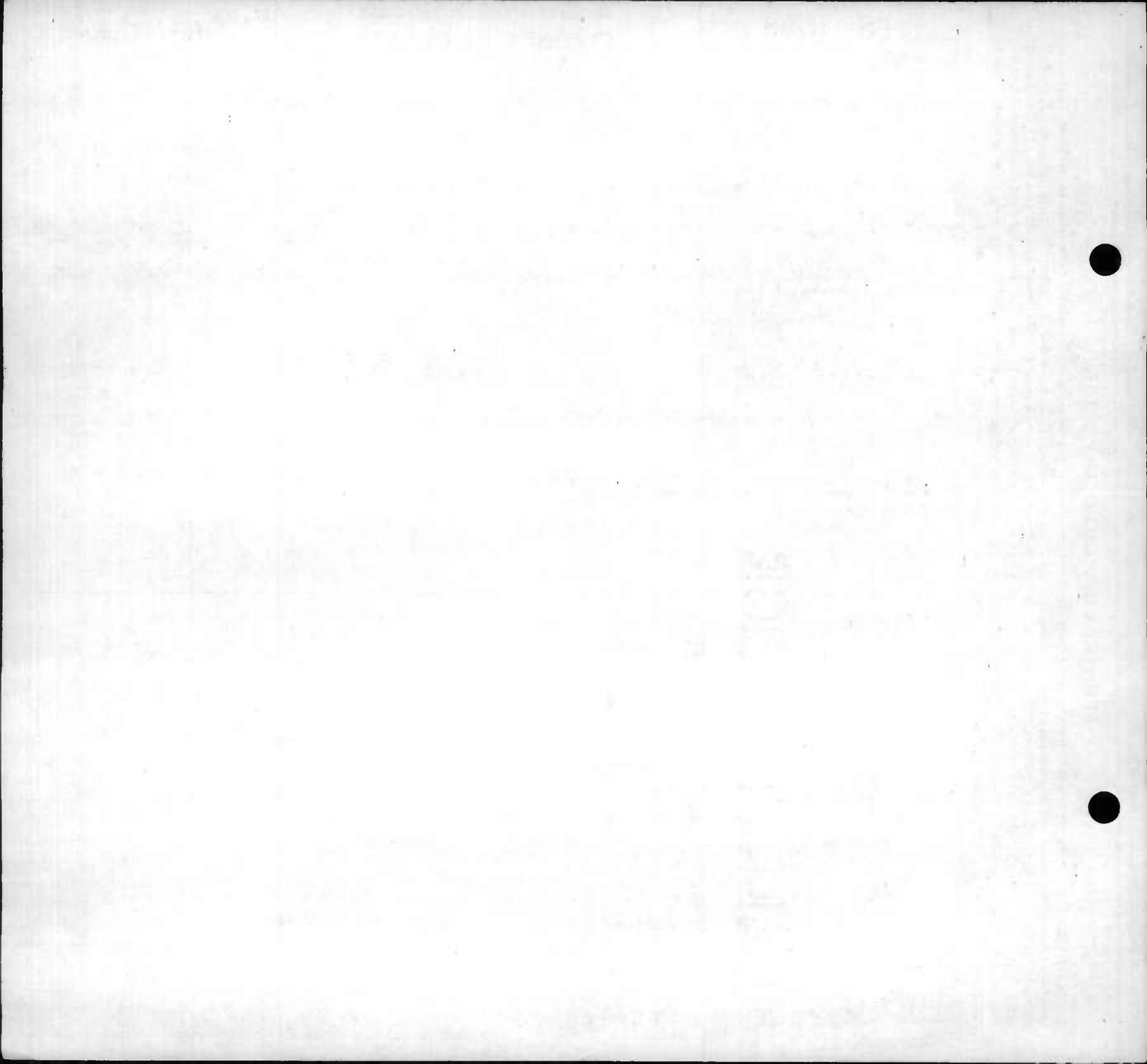
25B. NAME OF REGISTRAR

Robert E. Talley MD

25C. FUNERAL DIRECTOR

Frank A. Seitz 814 W 36th St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 65 0769				CERTIFICATE OF DEATH X Registered No. 65 0769	
1. NAME OF DECEASED (Type or Print) Cather, George William			2. DATE AND HOUR OF DEATH 1/20/65 1:25 P.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore County C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 21208 D. STREET ADDRESS (If rural, give location) 502 Shamrock Lane		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) D	8. DATE OF BIRTH 3/15/1909	9. AGE (In years last birthday) 55 Yrs.	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Hennegan-Bates (Jewelry)		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Robert			14. MOTHER'S MAIDEN NAME Annie Goebel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-6320		17. INFORMANT ADDRESS Montebello State Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cancer of esophagus, advanced			INTERVAL BETWEEN ONSET AND DEATH 9 months		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/30/64 19 to 1/20/65 19, that (I) (we) last saw the deceased alive on 1/20/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Prlando C. Ramos				23B. DATE SIGNED 1/20/65	
23C. PHYSICIAN'S NAME (Type) Prlando C. Ramos				23D. ADDRESS Montebello State Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY OR CREMATORY Western	
24D. LOCATION (City, town, or county) (State) Bethesda, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Loring Byers, Randall			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0770

BIRTH NO. 65 0770

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HANNAH REICHEL

2. DATE AND HOUR OF DEATH

1-20-65 9:25 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

THE HOSPITAL FOR THE WOMEN OF MARYLAND.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND - Balto.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location)

313 WILLOW AVE

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

8-23-04

9. AGE (In years last birthday)

60

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

WEST PHALEN, GERMANY

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Heinreich Laue

14. MOTHER'S MAIDEN NAME

Anna Buessenschutt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-46-6605

17. INFORMANT

chart

ADDRESS

18. 3-27-1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) AC Pulmonary heart Edema
DUE TO
Cor Pulmonale sec
(B) DUE TO
to Ch Emphysema
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-20 19 65 to 1-20 19 65, that (I) (we) last saw the deceased alive on 1-20: 9:25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Diadema B. Simon

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-20-65

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-23-1965

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Baltimore Co.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 22 1965

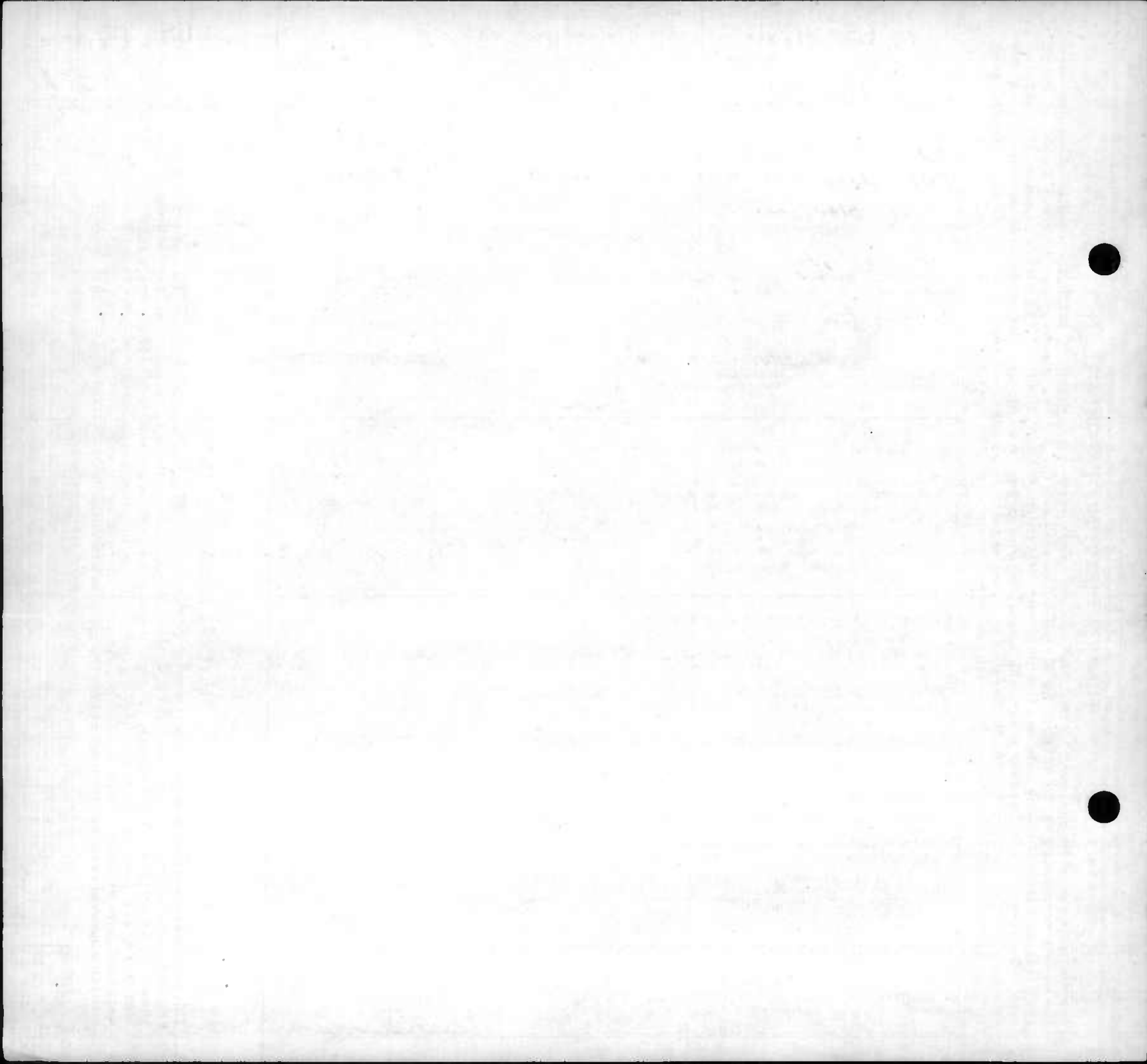
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lillian's Funeral Home 7401 Belair Rd

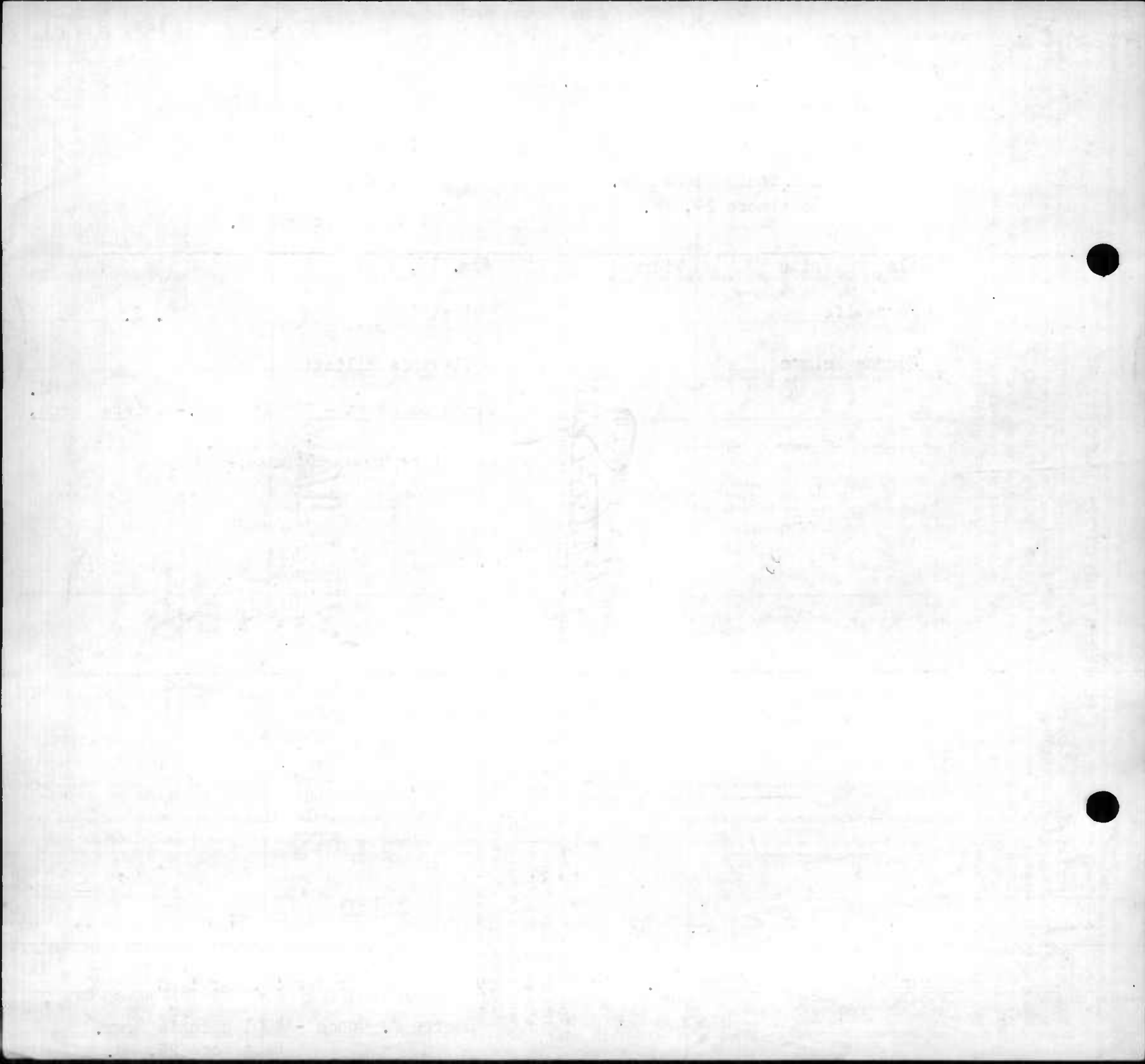
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

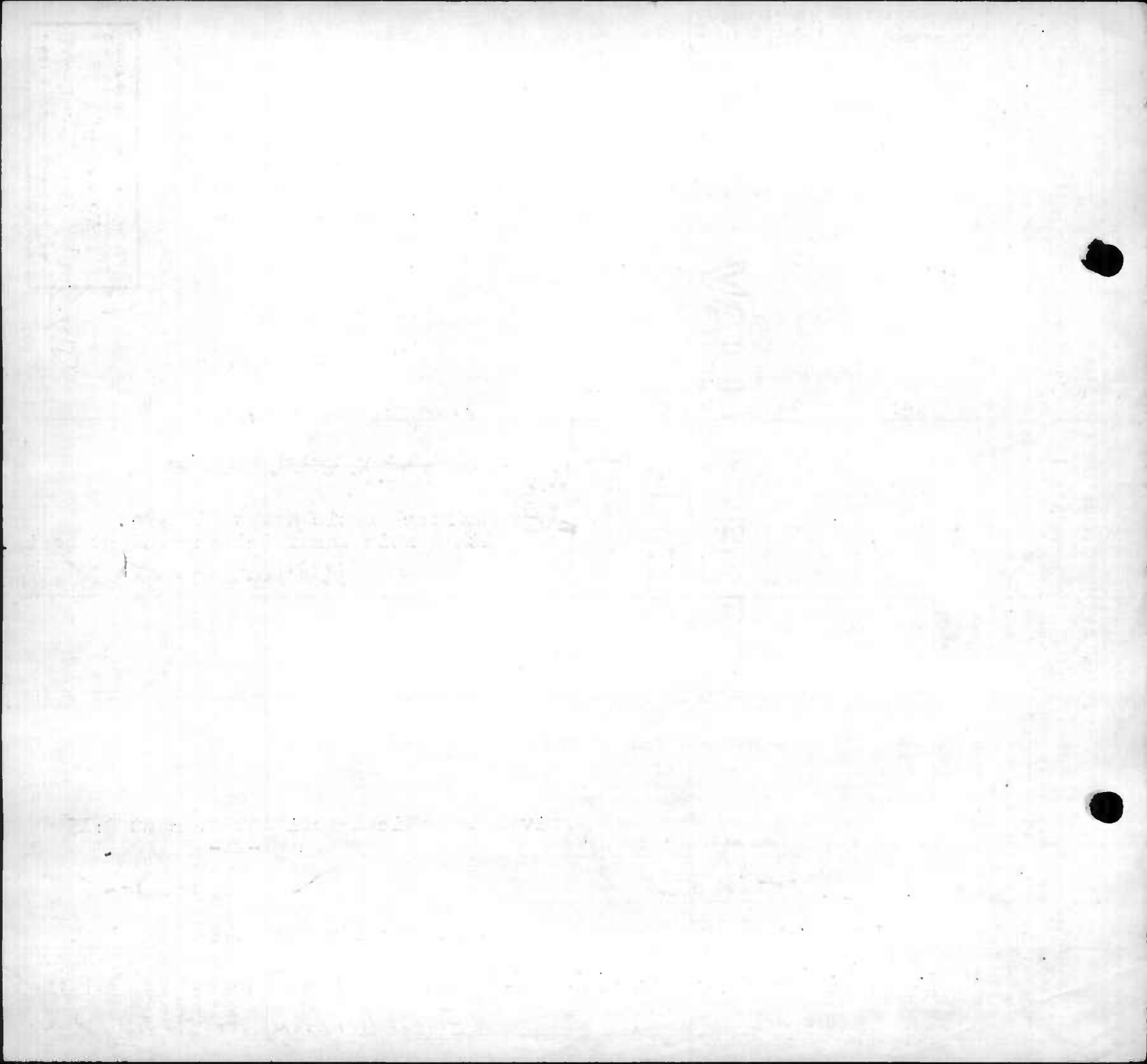
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0771	
BIRTH NO. 65 077159362		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) EDNA MAY WEIDENHOFT		2. DATE AND HOUR OF DEATH 1/19/65 11:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 401 South Wickam Rd. Baltimore 29, Md.		A. STATE Maryland B. COUNTY Baltimore			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH Aug. 15, 1887		9. AGE (In years last birthday) 77		10. CITIZEN OF WHAT COUNTRY U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Eugene McLane		14. MOTHER'S MAIDEN NAME Virginia Elliott		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Frank Geisbert - 204 Lake Rd. - Riviera Beach, Md.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Coronary Occlusion - Massive myocardial infarction 2 min.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Atherosclerotic CV Disease 2 yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1-7 1961 to 1-19 1965, that (I) (we) last saw the deceased alive on 6/3 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Schaeffer				23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFFER				23D. ADDRESS 401 Randow Road - Balt. Md. - 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/1965		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION Frederick, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy. Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

NON-Medical Certificate		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Ross, David		1/21/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				A. STATE Maryland			
(If not in hospital or institution, give street address or location)				B. COUNTY 10-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 808 N. Central Ave.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 5/30/93	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		
10A. USUAL OCCUPATION			10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) BALTO. Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Ross				14. MOTHER'S MAIDEN NAME Florence Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI				16. SOCIAL SECURITY NO.		17. INFORMANT Rev. Herman B. Ross	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Sudden death of unknown cause (A) Atherosclerotic Heart Disease. DUE TO with aortic insufficiency and stenosis. (C) <u>Widow M. Griffin</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on Arrived in Medical Accident room at 9:15 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 1-21-65 DOA.							
23A. SIGNATURE S. L. Johnson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-21-65	
23C. PHYSICIAN'S NAME (Type) Steve D. Johnson				23D. ADDRESS John Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-25-65		BALTO. NAT. Cem.		BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 22 1965		Robert E. Farley, M.D.		E. O. Wilson		1000 Brantley Ave.	



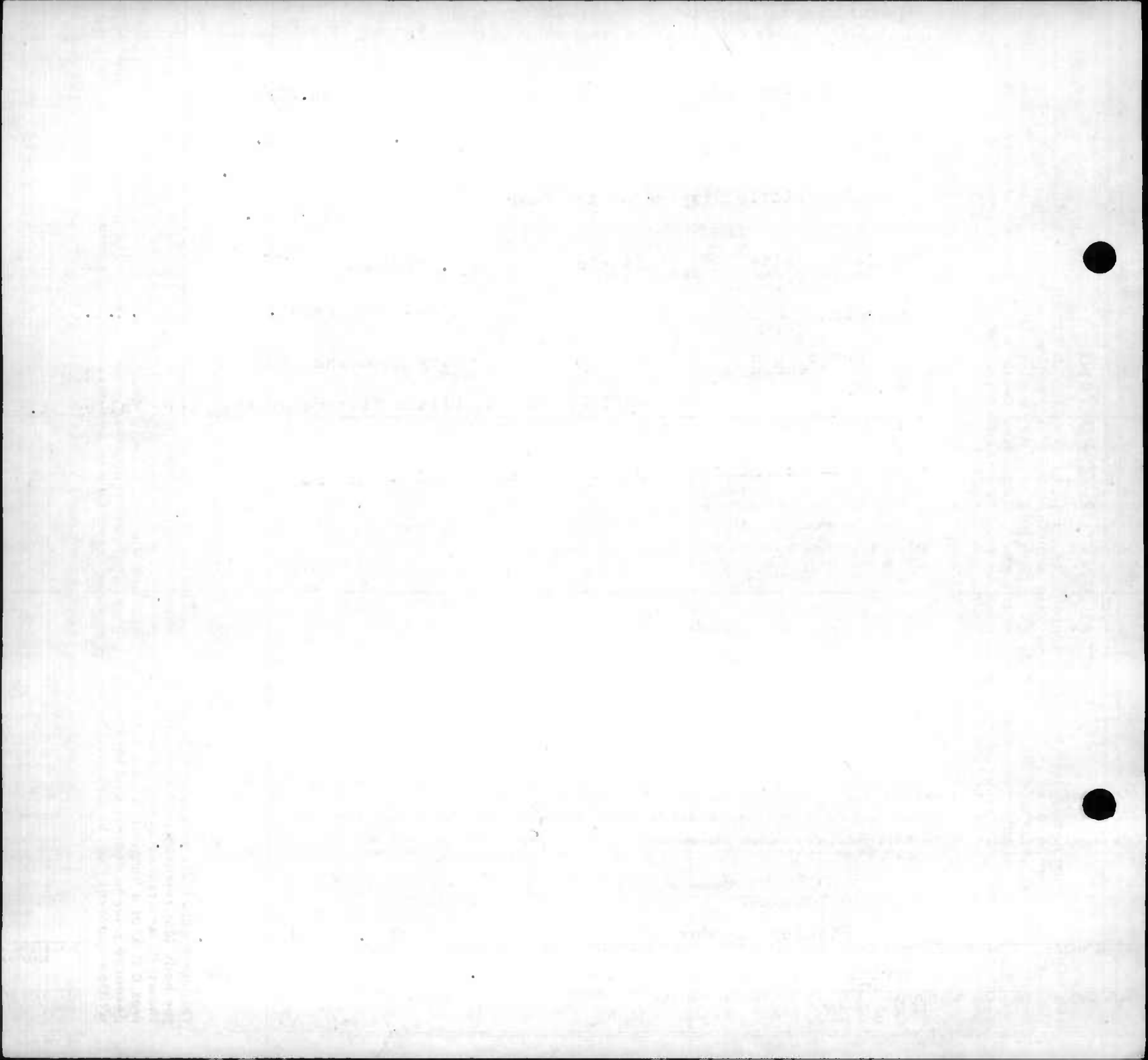
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 0773	
M.E. CASE NO. 59374		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
CLARENCE GRIFFIN			1-20-65 10:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL			Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			3358 Wilkins Avenue - 21229		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	SINGLE	AUG. 13, 1926	38	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CLERK				VIRGINIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CLARENCE GRIFFIN			ELIZABETH PARKS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				VIRGINIA SHANNON - 2026 Northurst WAY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
			(A) Multiple traumatic injuries DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Street		Wilkins Avenue and Primson Street	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) (Min.)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Pedestrian - Struck by auto	
1 20 '65 P.					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		CHARLES S. PETTY, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
BURIAL		1-23-65		SUNSET MEM. CEM.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JAN 22 1965		Robert E. Fisher, M.D.		WITZKE FUNERAL DIR. 4101 EDMONDSON AVE.	
				CLARKSBURG, W. VA.	

WALLACE P. FORT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 0774	
BIRTH NO. 65 0774		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Frances Leda			2. DATE AND HOUR OF DEATH Jan. 21/65 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisyers of the Poor			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 10-01 B. COUNTY 202 W. Monumet St. Baltimore Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. D. STREET ADDRESS (If rural, give location) I200 Valley St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Nov. 21/1885	9. AGE (In years last birthday) 79	10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Natrona Penna.	
13. FATHER'S NAME Goerge Leda			14. MOTHER'S MAIDEN NAME Mary Zimcovak		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 30 2580		17. INFORMANT A Little Sistera of the Poor Valley St.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from 1960 to Jan 21 1965, that (I) (we) last saw the deceased alive on Jan 21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 8 P.M.			23A. SIGNATURE <i>Stanley Ankudas</i>		
23B. DATE SIGNED 1.20.65			23C. PHYSICIAN'S NAME (Type) Stanley Ankudas		
23D. ADDRESS 1802 W. Baltimore Md. 21223			23E. M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24C. NAME OF CEMETERY or CREMATORY Cathedral Cem.		
24B. DATE REC'D BY HEALTH DEPT. JAN 22 1965			24D. ADDRESS Baltimore		
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965			25B. NAME OF REGISTRAR Robert E. Farley		
25C. FUNERAL DIRECTOR Philip Herurg			25D. ADDRESS 2024 Orleans St		



BIRTH NO. 65 0775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____M.E. CASE NO. 59373

1. NAME OF DECEASED (Type or Print) JESSE FOWLKES				2. DATE AND HOUR PRONOUNCED DEAD January 20, 1965 11:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 808 N. Bond Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 2-5-1920	9. AGE (In years last birthday) 46	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Balt. City H.H.		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hessie Fowlkes				14. MOTHER'S MAIDEN NAME Maude Hilliard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES U. War I				16. SOCIAL SECURITY NO. 219-073027		17. INFORMANT ADDRESS Doris Fowlkes 2900 E. Federal st	
18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-21-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-25-65		23C. NAME of CEMETERY or CREMATORY VETERAN-NATIONAL		23D. LOCATION (City, town, or county) (State) BALTO. CITY	
24A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		24B. NAME OF REGISTRAR R. D. E. F. D. M. D.		24C. FUNERAL DIRECTOR JOSEPH KNIGHT		24D. ADDRESS 1639 N. BROADWAY	

WALLER POLICE

1-25-65 VETERAN-NATIONAL BIRTH

1-25-65

FUNERAL DIRECTOR: IMPORTANT

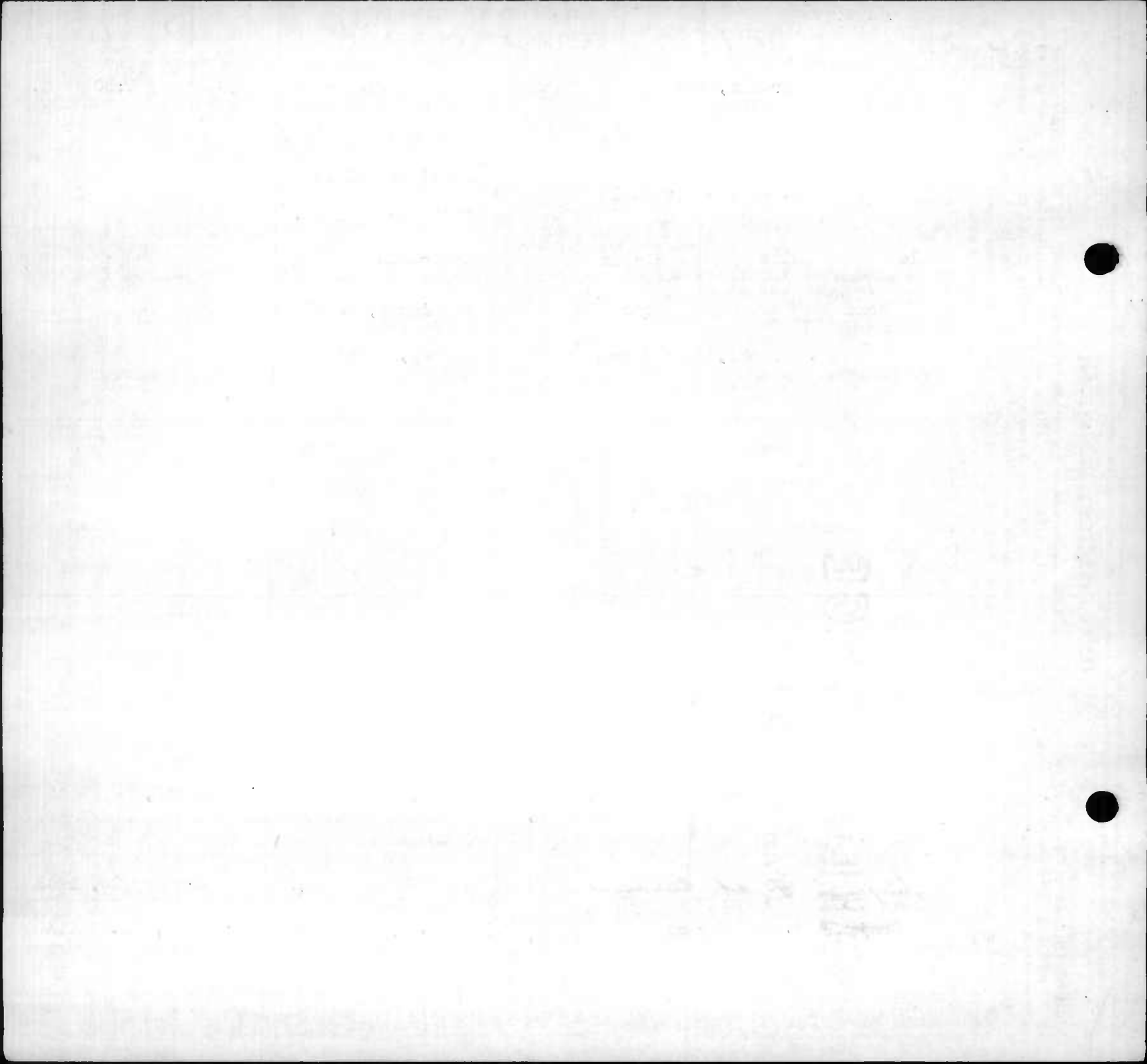
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0776	
BIRTH NO. 65 0776				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) FRANCES C. GADDESS				2. DATE AND HOUR OF DEATH 1-28-65 10¹⁰ A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE HOSPITAL FOR THE WOMEN OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 12-06 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND D. STREET ADDRESS (If rural, give location) 2742 MARYLAND AVE			
5. SEX F	6. RACE W	7. MARRIED , NEVER MARRIED WIDOWED , DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH 11-24-90	9. AGE (In years last birthday) 74	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired CLERK-WHITELOCK BOOTERY				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME JOHN BASCELL GADDESS				14. MOTHER'S MAIDEN NAME MARGARET ANNE FOX			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-14-3638		17. INFORMANT MARGARET A. GADDESS ADDRESS 2742 MARYLAND AVE	
18. 199-221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Thrombosis in coronary artery DUE TO (B) Arteriosclerosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 yrs + 2 yrs +	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-19 19 65 to 1-20 19 65 , that (I) (we) last saw the deceased alive on 10^{pm} 1-20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ingenta A. Topand				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) INGENTA TOPAND				23D. ADDRESS Women's Hospital, Balt. 17, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/23/65		24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR H.W. MEARS & SON		ADDRESS 805 N. CALVERT ST.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

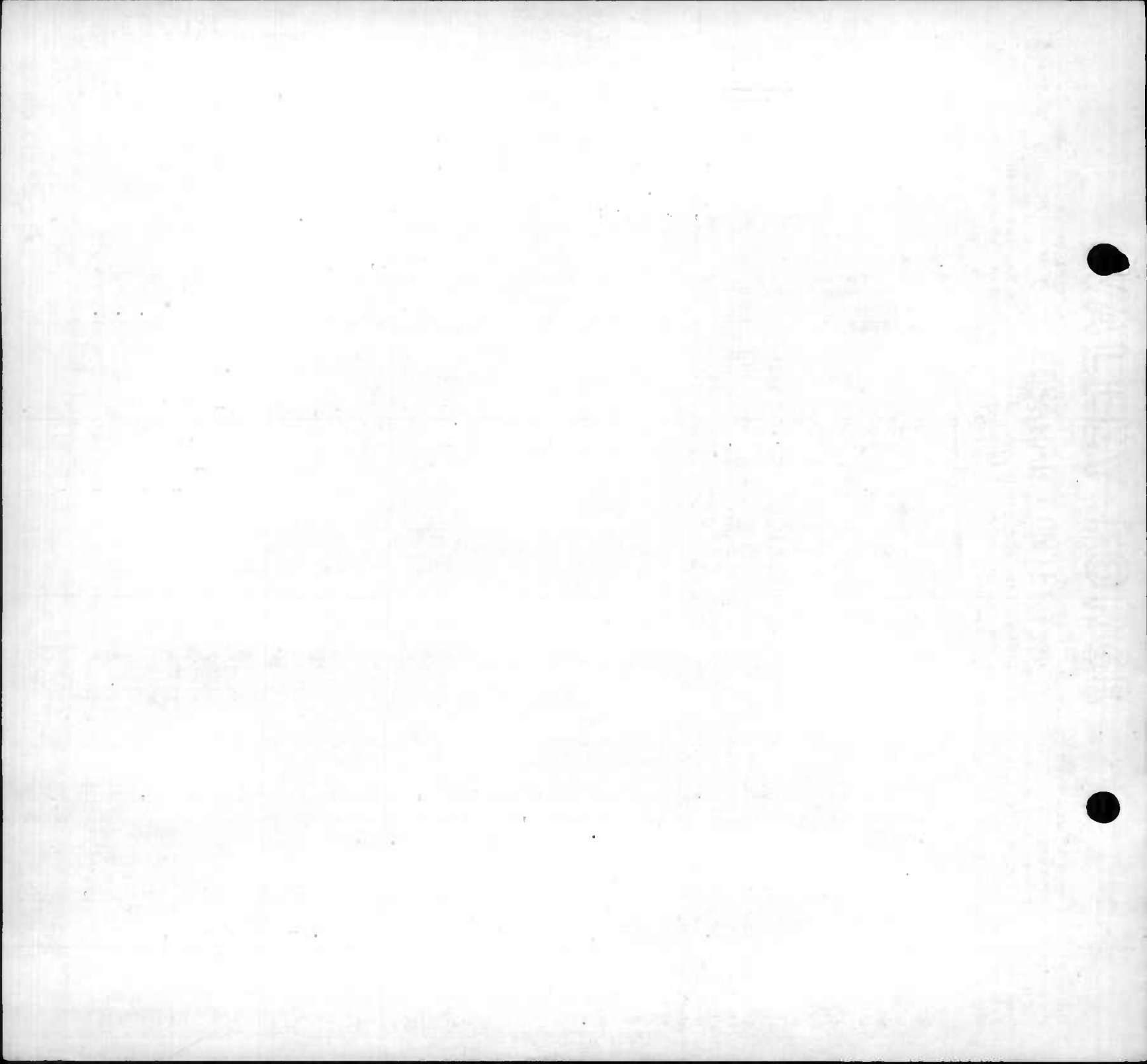
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <u>65 0777 4</u>	
BIRTH NO. <u>65 0777</u>		M.E. CASE NO.								2. DATE AND HOUR OF DEATH <u>January 20, 1965</u> <u>2:00</u> A.M.	
1. NAME OF DECEASED (Type or Print) <u>Brooks, John</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1-05</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21231</u> D. STREET ADDRESS (If rural, give location) <u>2211 Portugal St.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>1-20-1965</u>		9. AGE (In years last birthday) <u>1</u>		If Under 1 Yr. Months: Days: <u>1</u>		If Under 24 Hrs. Hours: Min. <u>1</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>1</u>			
13. FATHER'S NAME <u>Brooks, John Joseph</u>				14. MOTHER'S MAIDEN NAME <u>Murphy, Patricia</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>PREMATURITY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Prematurity</u> DUE TO (B) <u> </u> DUE TO (C) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>											
19A. DATE OF OPERATION <u> </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u> </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>							
22. I certify that (I) (this hospital) attended the deceased from <u>January 20, 1965</u> to <u>January 20, 1965</u> , that (I) (we) lost saw the deceased alive on <u>January 20, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Benjamin V. del Carmen</u> M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 20, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Benjamin V. del Carmen</u>				23D. ADDRESS M.D. <u>1400 N. Caroline St. Baltimore, Md. 21213</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u> </u>		24B. DATE <u>JAN 21 1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u> </u>				24D. LOCATION (City, town, or county) (State) <u> </u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>				ADDRESS <u> </u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 1-65-0778	
BIRTH NO. 65-01149				M.E. CASE NO. 65 0778	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Baby Barbara Griffin				January 18, 1965 1:45a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore 17, Maryland				A. STATE Maryland B. COUNTY 28-03	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 4512 Fairfax Rd.	
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	
8. DATE OF BIRTH January 17, 1965		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Griffin	
14. MOTHER'S MAIDEN NAME Barbara Thompson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Barbara Griffin, mother-		ADDRESS 4512 Fairfax Rd.			
18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ACUTE RESPIRATORY DISTRESS SYNDROME ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Respiratory Distress Syndrome (B) Prematurity (C)	
INTERVAL BETWEEN ONSET AND DEATH 1-17-65 - 1-18-65				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 17, 1965 to January 18, 1965, that (I) (we) last saw the deceased alive on January 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vincent R. Blake M.D.				23B. DATE SIGNED January 18, 1965	
23C. PHYSICIAN'S NAME (Type) Vincent R. Blake				23D. ADDRESS M.D. 1514 Division St. - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JAN 21 1965		24C. NAME OF CEMETERY OR CREMATOR	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
25D. ADDRESS		25E. ADDRESS			



SAB 47-86-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0779

BIRTH NO. 65 0779

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Copper

2. DATE AND HOUR OF DEATH

1-19-1965

7.30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)Baltimore City Hospitals,
4940 Eastern Avenue,
Baltimore, Maryland-21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Ann Arundel

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Pasadena 52-00

D. STREET ADDRESS (If rural, give location)

Box 37, Sunset Knoll Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7-23-1888

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret. Eng.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

GEORGE V. COOPER

14. MOTHER'S MAIDEN NAME

ELIZ. ANGEL

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

18.

331X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Pneumonia

3 days

(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

ANTECEDENT CAUSES

(B)
DUE TO

Cerebrovascular Accident

2½ years

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(C)
DUE TO

Arteriosclerosis-Generalized

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Thoracic Aortic Arch Aneurysm

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-8-19 65 to 1-19-19 65,
that (I) (we) last saw the deceased alive on 1-19-19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Robert Cooke

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

1-19-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Robert Cooke

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1/22/65

24C. NAME OF CEMETERY or CREMATORY

CEDAR HILL

24D. LOCATION

(City, town, or county)

BALTO, MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 22 1965

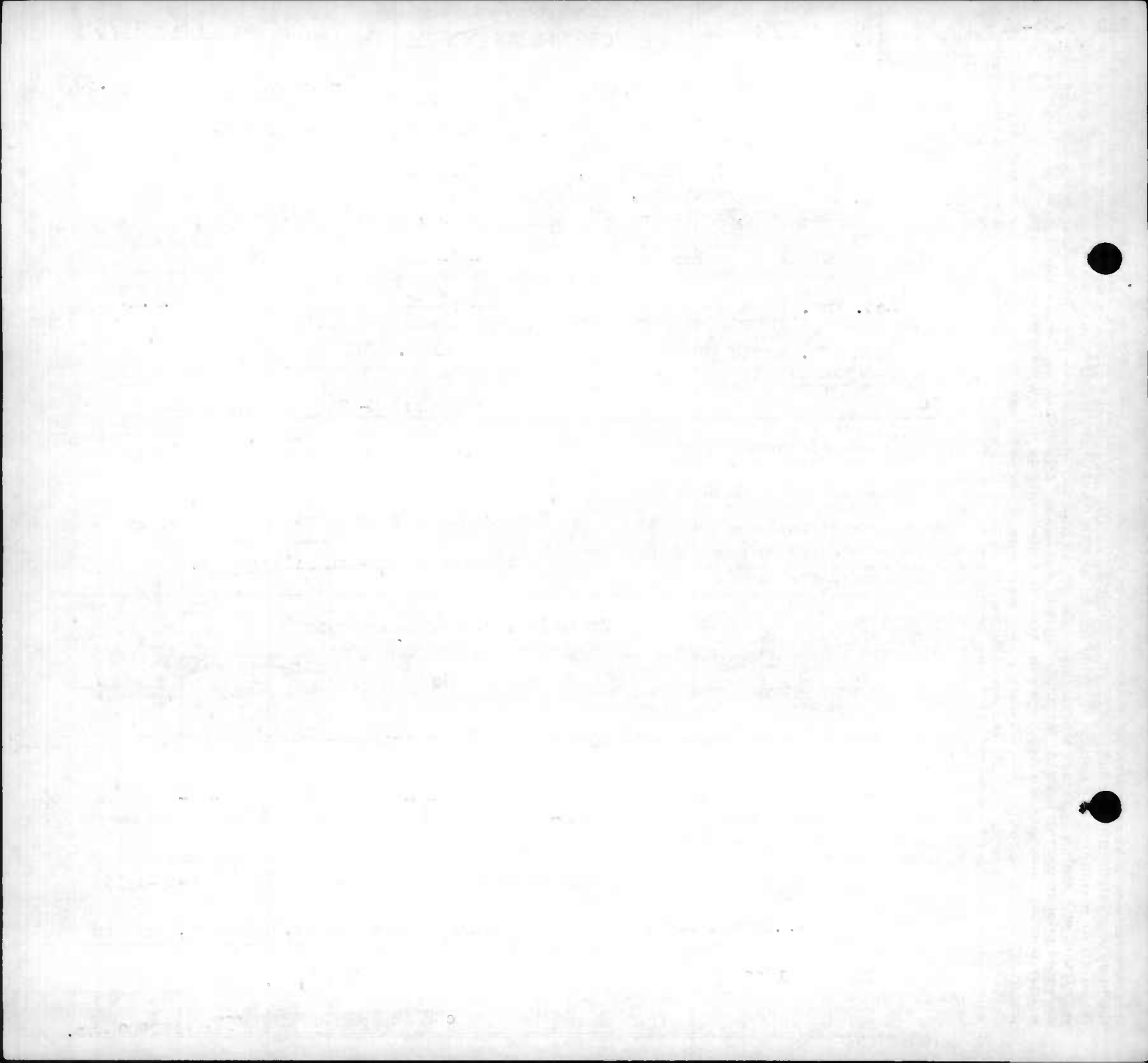
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

McCULLY FUNERAL HOME 237 Payapasco Ave.

ADDRESS



1
D-230

65 0780

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0780

1. NAME OF DECEASED (Type or Print) ARTHUR N. DOUGHTY		2. DATE AND HOUR PRONOUNCED DEAD January 20, 1965 10:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) S. Baltimore General		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3612 9th St.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 6-28-98
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carp.		10B. KIND OF BUSINESS OR INDUSTRY Self.	11. BIRTHPLACE (State or foreign country) Ind.
13. FATHER'S NAME Joe.		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Family - Same
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Multiple traumatic injuries DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fort Avenue and Covington St.
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) 1 18 65 6:35p		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Pedestrian struck by auto
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breiteneker M.D. EXAMINER'S NAME (Type) Rudiger Breiteneker CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-20-65			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE 1-23-65	23C. NAME OF CEMETERY or CREMATORY Green Haven	23D. LOCATION (City, town, or county) (State) Baltimore
24A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		24B. NAME OF REGISTRAR Robert E. Taylor	24C. FUNERAL DIRECTOR ADDRESS McCully - 130 E. Fort An.

V869.2

WALLEY FORT

W 256

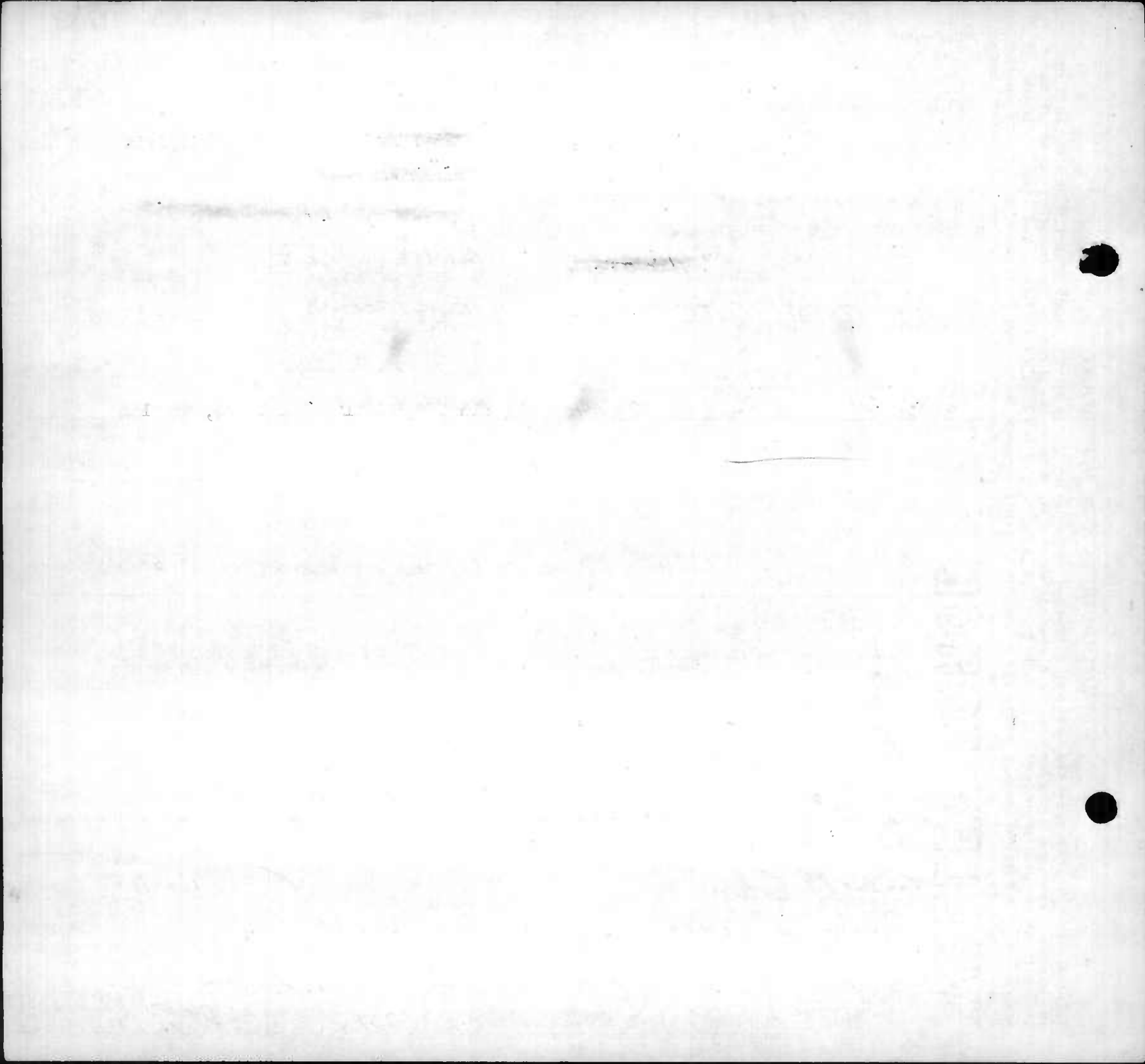
BIRTH NO. 65 0781				BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0781			
M.E. CASE NO. 59371											
1. NAME OF DECEASED (Type or Print) RICHARD WINFIELD WAGNER				2. DATE AND HOUR PRONOUNCED DEAD January 20, 1965 6:00 a M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital DOA				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New Jersey B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newark V-27 D. STREET ADDRESS (If rural, give location) 60 Bregaw Avenue							
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH June 10, 1929	9. AGE (In years last birthday) 35	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10B. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Altoona, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Walter Wagner				14. MOTHER'S MAIDEN NAME Bessie Lowe							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean 1948-'53		16. SOCIAL SECURITY NO. 174-20-0063		17. INFORMANT W. Wm. Wagner Mt. Lebanon, Pa.				ADDRESS			
18. EB1610 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Crushing head and chest injuries (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) John F. Kennedy Highway 5-3-00							
21D. TIME OF INJURY (APPROX.) 1 20 65 4:35a		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Truck ran into rear of another truck							
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breiteneker M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-20-65											
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/23/65		23C. NAME OF CEMETERY or CREMATORY Rose Hill Cemetery		23D. LOCATION (City, town, or county) (State) Logan Township Blair Co. Pa.					
24A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		24B. NAME OF REGISTRAR Robert E. Farber M.D.		24C. FUNERAL DIRECTOR Geo. Pfeiffer Glen Rock, Pa.				ADDRESS			

WILLY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0782				CITY HEALTH DEPARTMENT		Registered No. 65 0782	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) TYLER, BETTY Ann				2. DATE AND HOUR OF DEATH 21 JANUARY 1965 6 19 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, INC.		(If not in hospital or institution, give street address or location)		A. STATE XXXXXXXXX		B. COUNTY Virginia	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXXXXX		Oak Grove	
				D. STREET ADDRESS (If rural, give location) V-43			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 2/11/19	9. AGE (In years last birthday) 45	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS			10B. KIND OF BUSINESS OR INDUSTRY TEXTILE MILLS		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gordon				14. MOTHER'S MAIDEN NAME Dorothy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 227-46-3/32		17. INFORMANT Sinai Hospital Baltimore, Maryland		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 241X I				CAUSE OF DEATH (A) COR PULMONALE DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CHRONIC OBSTRUCTIVE AIRWAY DISEASE DUE TO		6 months	
				(C) ACUTE & CHRONIC BRONCHIAL ASTHMA		39 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE							
19A. DATE OF OPERATION 1/19/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHECTOMY FOR OBSTRUCTIVE AIRWAY DISEASE		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 1 JANUARY 1965 to 21 JANUARY 1965 , that (we) last saw the deceased alive on 21 JANUARY 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barry M. Cohen				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/21/65	
23C. PHYSICIAN'S NAME (Type) BARRY M. COHEN				23D. ADDRESS M.D. Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/21/65		24C. NAME OF CEMETERY or CREMATORY Oak Grove Cemetery		24D. LOCATION (City, town, or county) (State) Oak Grove, VA.	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm. F. Fickner & Sons		ADDRESS Baltimore, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 0783

BIRTH NO. 65 0783

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Lois M. Kincaid

2. DATE AND HOUR OF DEATH

JAN 22 - 1965 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

626 Wildwood - Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland 16-08

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

626 Wildwood Parkway

5. SEX

FEMALE White

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6-30-1903

9. AGE (In years
last birthday)

61

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

Sur-Office

11. BIRTHPLACE (State or foreign country)

Baltimore - Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George M.R. Miller

14. MOTHER'S MAIDEN NAME

Anna F. Keller

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-36-4924

17. INFORMANT

Charles J. Kincaid

ADDRESS

18.

422.11

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) arteriosclerotic Cardio
Vascular Disease

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug. 28, 1964 to JAN. 22, 1965,
that (I) (we) last saw the deceased alive on JAN. 21, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry L. Knipp

M.D.

Attending
Phys.

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1-23-65

23C. PHYSICIAN'S
NAME (Type)

HARRY L. KNIPP

M.D.

23D. ADDRESS

416 EDMONDSON AV.
BALTO. MD. 21229

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-26-65

24C. NAME OF CEMETERY OR CREMATORY

London Park Cem. Balto. Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

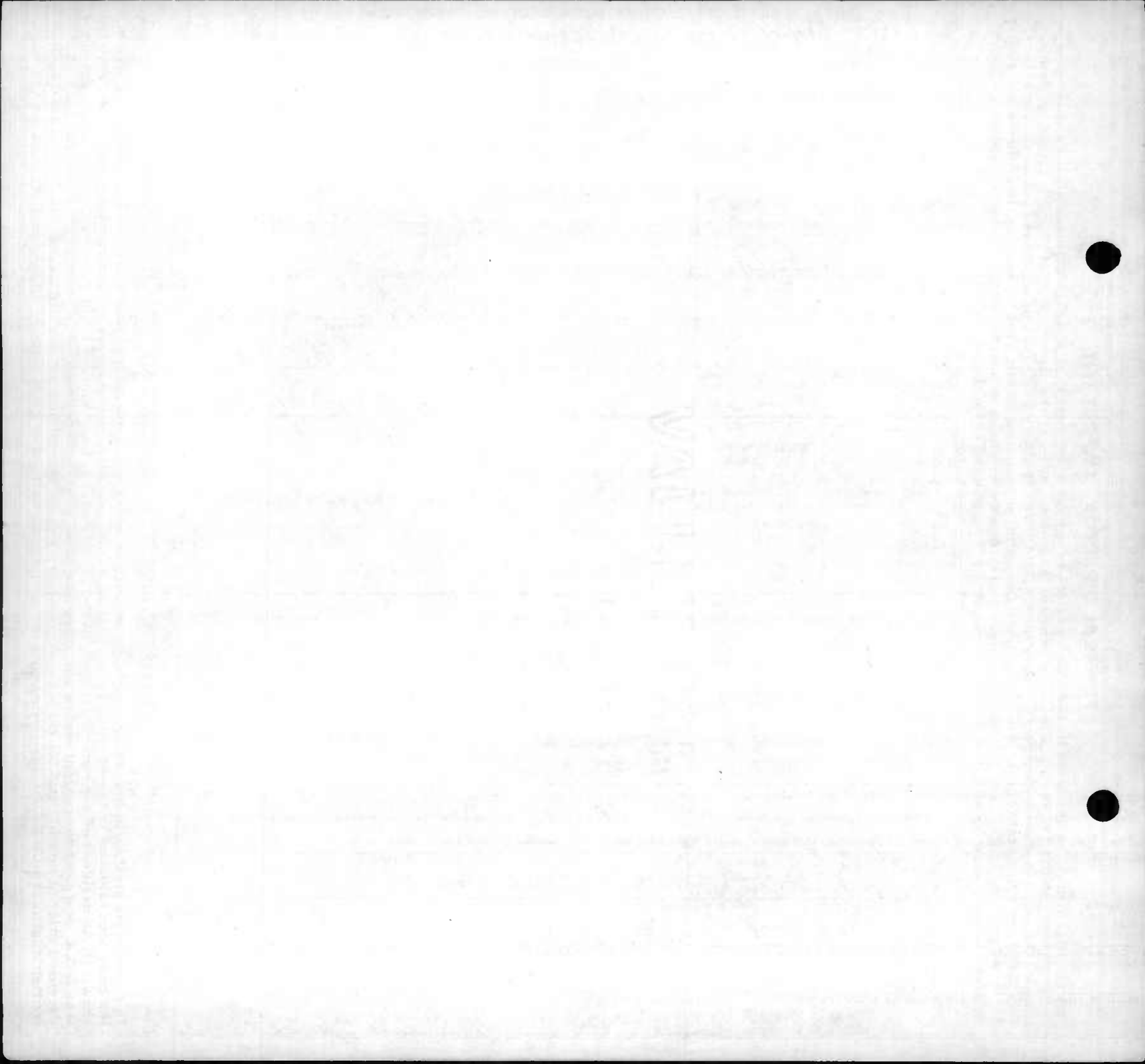
Robert E. Farley M.D.

25C. FUNERAL DIRECTOR

F. B. Whipple

ADDRESS

1300 Eastview Pl.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0784		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0784	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BELL, GERTRUDE ELLEN		1 18 65 1:00 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227			
		D. STREET ADDRESS (If rural, give location) 2911 OHIO AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 12 12 83	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN MCCORMICK		14. MOTHER'S MAIDEN NAME SARAH RECKORD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS. FRANCES KESTLER (daughter) ST AGNES HOSP RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardio-vascular accid. (B) Myocardial infarction (C) _____		INTERVAL BETWEEN ONSET AND DEATH		ADDRESS SAME AS #4	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 1 19 65 to 1 18 19 65, that (I) (we) last saw the deceased alive on 1 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pedro F. Bajo				23B. DATE SIGNED Jan. 18, 1965	
23C. PHYSICIAN'S NAME (Type) PEDRO F. BAJO				23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN. 22/65		24C. NAME OF CEMETERY or CREMATORY LOUDDON PARK CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR R.V. SINGLETON, GLEN BURNIE, MARYLAND			



FUNERAL DIRECTOR: IMPORTANT

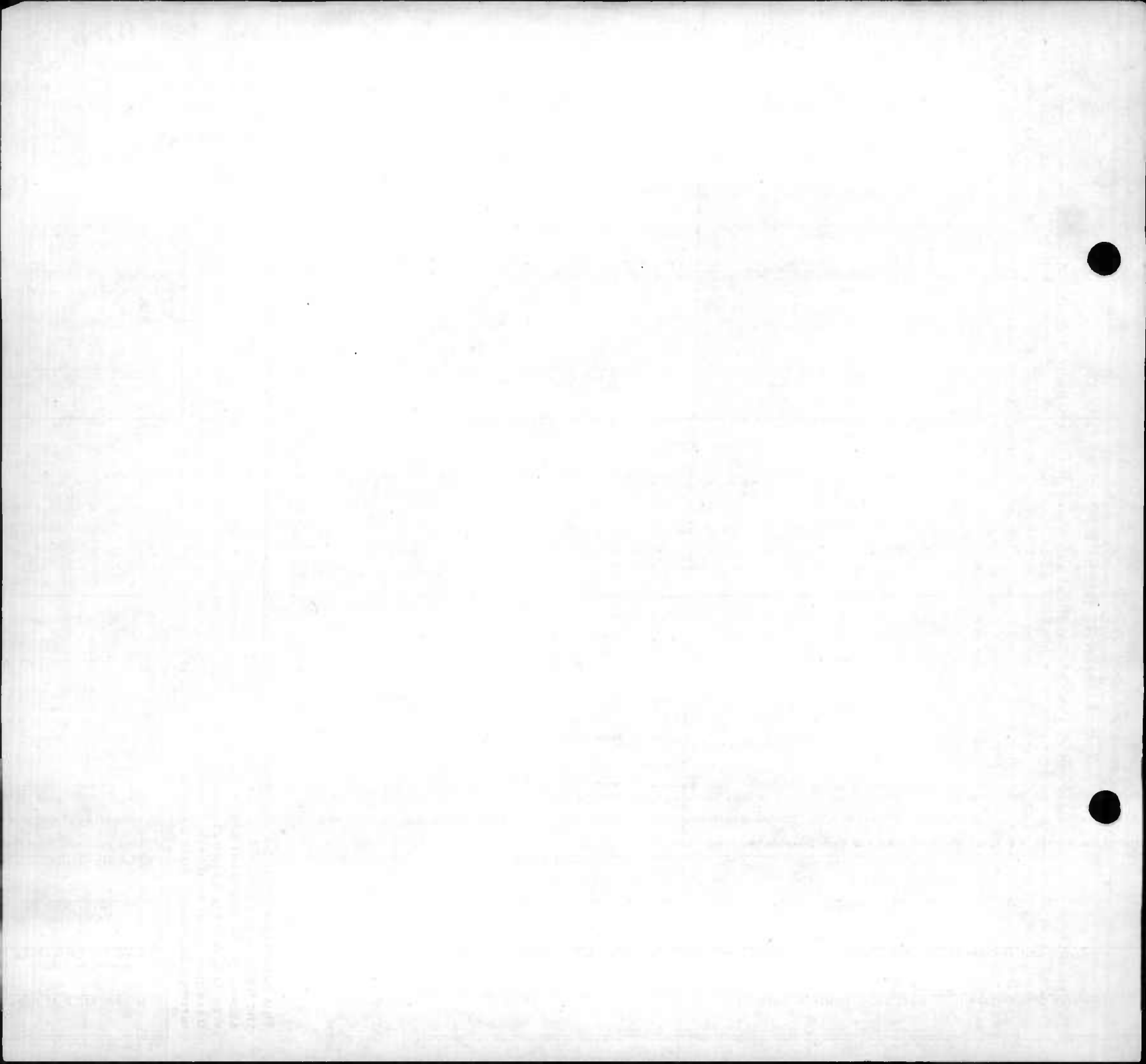
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 0785</u>	
BIRTH NO. <u>65 0785</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HOLMAN, BABY BOY</u>				2. DATE AND HOUR OF DEATH <u>1 20 65</u> <u>2:40P</u> M.			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>25-42</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST AGNES HOSPITAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>3031 MALLVIEW ROAD</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify) <u>INFANT</u>	8. DATE OF BIRTH <u>1 20 65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Mins	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			13. FATHER'S NAME <u>JOSEPH M</u>				
14. MOTHER'S MAIDEN NAME <u>BONNIE SHILOH</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>BALTIMORE 29 MD ST AGNES HOSP RECORDS WILKENS & CATON</u>				
18. <u>773.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Congestive Heart Failure</u> (B) <u>Prematurity</u> (C) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1 20</u> 19 <u>65</u> to <u>1 20</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1 20</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>FE L. Rubin</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/20/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>FE L. RUBIN</u> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Chubbuck, Inc. 1328 Guilford Spring Rd.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

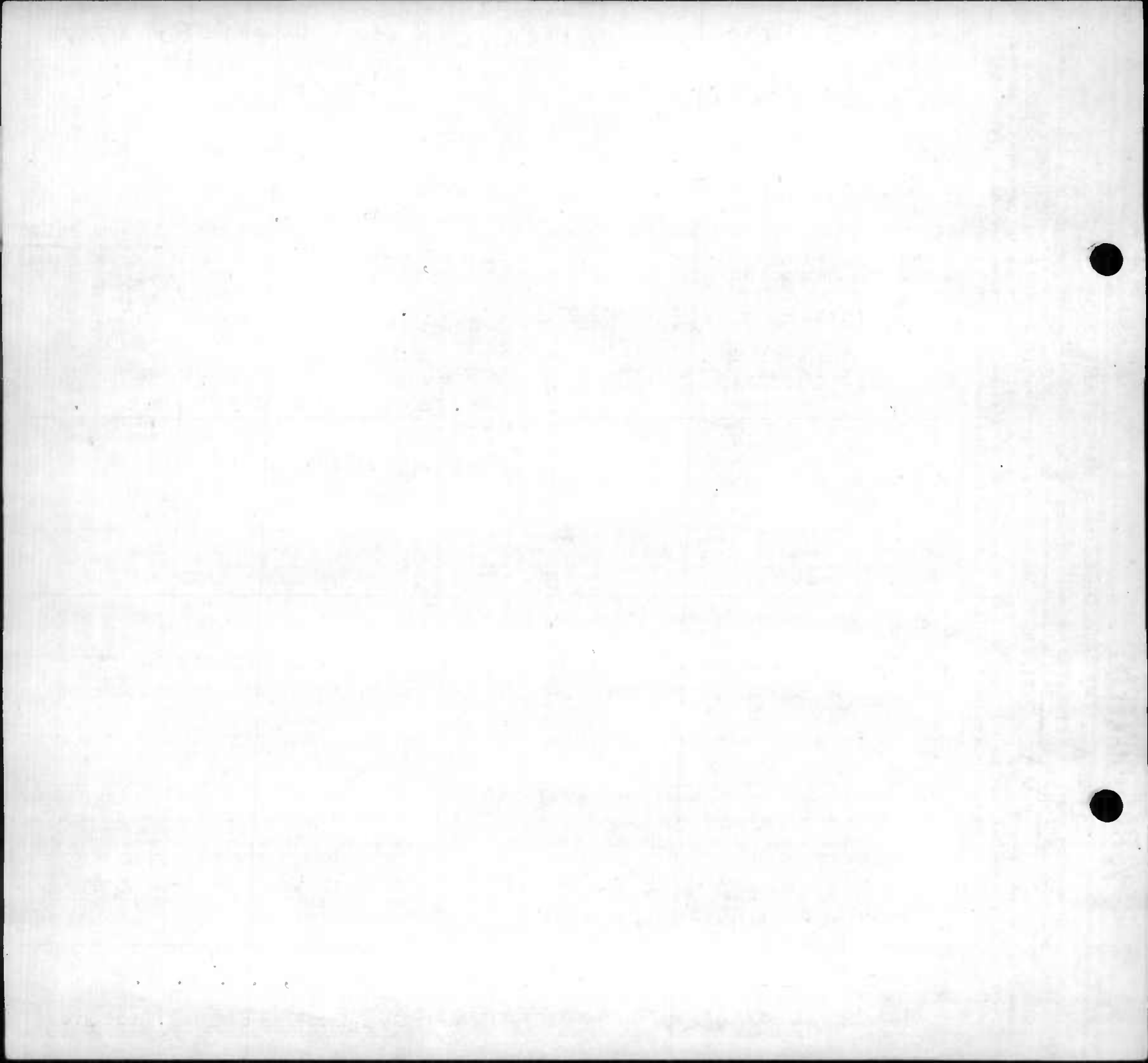
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0786	
BIRTH NO. 65 0786		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lower, Mrs. Carrie E.		2. DATE AND HOUR OF DEATH JAN. 23, 1965 3:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Keswick Home		A. STATE BALTIMORE, MARYLAND 13-07 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND D. STREET ADDRESS (If rural, give location) 700 W 40th St.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-14-1883	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MAHR, HENRY		14. MOTHER'S MAIDEN NAME DEITZ, MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS OTTO W. LOWER 1202 LAKESIDE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 280X I		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Arteriosclerosis (generalized) DUE TO (C) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 12 Days 2 years 16 years	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 30 1959 to January 23 1965 , that (I) (we) last saw the deceased alive on January 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger		M.D. Attending Phys. <input type="checkbox"/> M.D. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED January 23, 1965	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger		23D. ADDRESS M.D. 700 West 40th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/25/65		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY	
24D. LOCATION (City, town, or county) (State) PARKVILLE MD		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS ULURICH FUNERAL HOME 4210 BELAIR			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0787</u>	
BIRTH NO. <u>65 0787</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Kulick, Adolph L.</u>		2. DATE AND HOUR OF DEATH <u>1/23/65</u> <u>7:30</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Franklin Sq Hosp</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2402</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1213 Riverside Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>May 19, 1914</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Adolph Kulick</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Asman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. LaVerne Kulick 1213 Riverside Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Cerebral hemorrhage</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>1/23/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Byong Koo Kim</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/23/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Byong Koo Kim</u> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1 26 65</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mc Cully Funeral Home</u>		ADDRESS <u>130 E. Fort Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 0788</u>	
BIRTH NO. <u>65 0788</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Robert Proctor		1-21-65 4:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland, Baltimore Rural 103 Willow Court			
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 8-27-00	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		11. BIRTHPLACE (State or foreign country) Maryland N.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNK.				14. MOTHER'S MAIDEN NAME Mary Harper			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				RECORDS: B.C.H. 4940 Eastern Avenue #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.0 X 008.1 Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 3 Months			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia ? Bacterial ? Tuberculosis				? 1 Week			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No)		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
23D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		23E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		23F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-15 1965 to 1-21 1965, that (I) (we) last saw the deceased alive on 1-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Howard K. Rathbun				23B. DATE SIGNED 1-21-65			
23C. PHYSICIAN'S NAME (Type) Dr. Howard K. Rathbun				23D. ADDRESS 4940 Eastern Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-65		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR Morton Dyett		ADDRESS 916 BANA Ave.	

Letter from B.C.H.

1-28-65

M.H.

1
G. 125

65 0789

BALTIMORE CITY HEALTH DEPARTMENT

65 0789

BIRTH NO. 64-20404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Darrell Gibson 2. DATE AND HOUR PRONOUNCED DEAD Jan. 16, 1965 9:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Johns Hopkins Hospital 2030 Mura Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH 8-3-1964 9. AGE (In years last birthday) 5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Walter Gibson 14. MOTHER'S MAIDEN NAME Marsha Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS W. Gibson 1115 Shields Place

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hemorrhagic otitis media, bilateral DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE John E. Adams, M.D. EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED Jan. 16, 1965

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 1-22-65 23C. NAME OF CEMETERY or CREMATORY Mt. Auburn 23D. LOCATION (City, town, or county) (State) Baltimore Md.

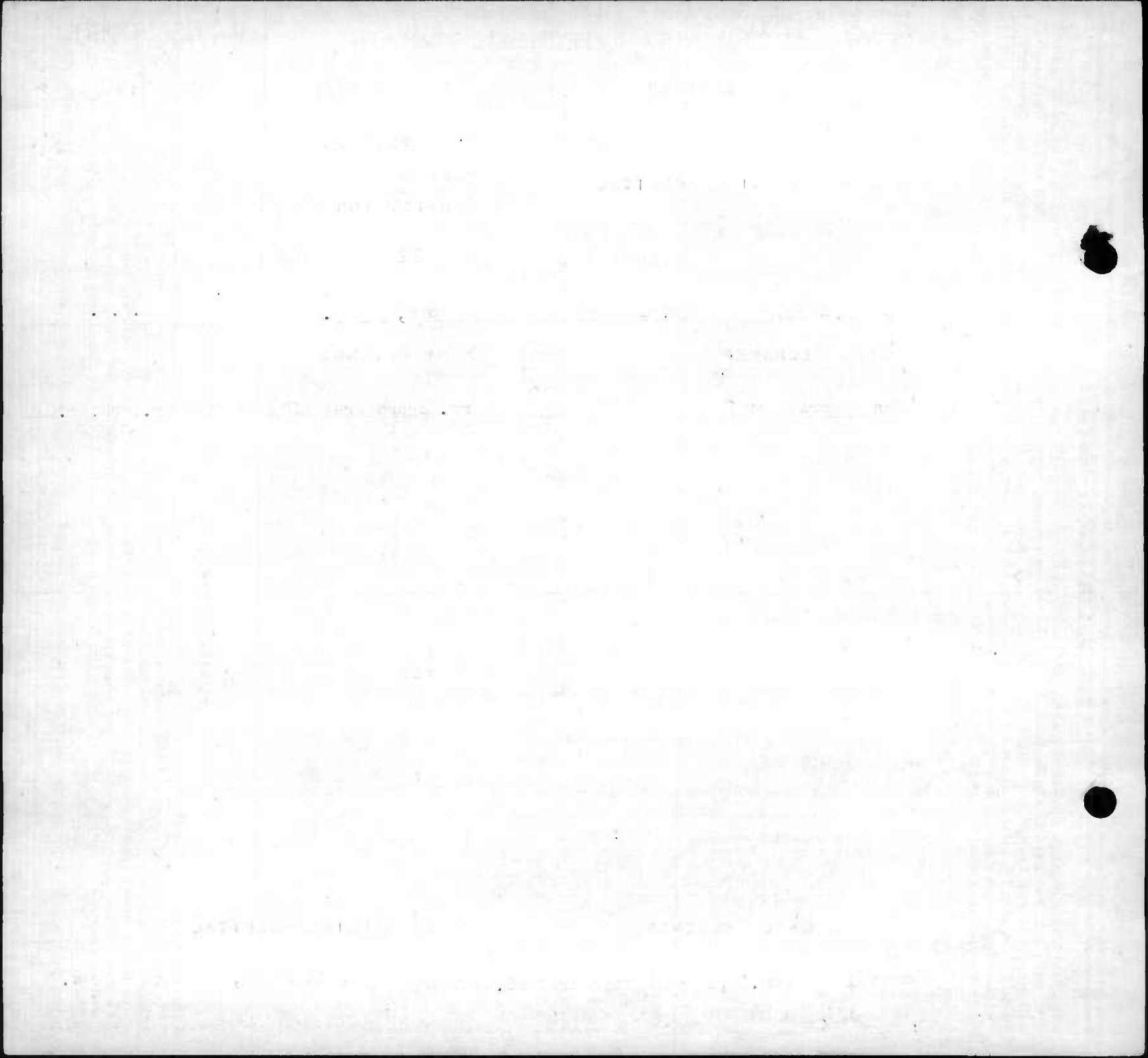
24A. DATE REC'D BY HEALTH DEPT. JAN 25 1965 24B. NAME OF REGISTRAR Robert E. Jarboe, M.D. 24C. FUNERAL DIRECTOR ADDRESS Morton & Dyett 916 PENNA. AVE.

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 0790</u>	
CERTIFICATE OF DEATH							
BIRTH NO. <u>65 0790</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>JAMES DELHAMER</u>				2. DATE AND HOUR OF DEATH <u>1/22/65</u> <u>1:40</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>PENNSYLVANIA</u> B. COUNTY <u>HELLAM</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>HELLAM</u>			
				D. STREET ADDRESS (If rural, give location) <u>TOURIST INN RD #1</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>5/25/22</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Motel Owner</u>		11. BIRTHPLACE (State or foreign country) <u>York, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN DELHAMER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ALLTAND</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Eugene Frey 4209 Webster Dr. York, Pa.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Multiple intestinal - cutaneous fistula</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>18 years</u>	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Regional enteritis</u>						<u>19 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> 19 <u>64</u> to <u>1/22</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>d. 1:40 PM</u>							
23A. SIGNATURE <u>Carl Bredenber</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/22/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>CARL BREDENBERG</u>				23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>Jan. 23, 1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gettysburg Nat. Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Gettysburg, Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. D. Fischer & Sons</u>		ADDRESS <u>1414 Pa. Ave. Balt. Md.</u>	

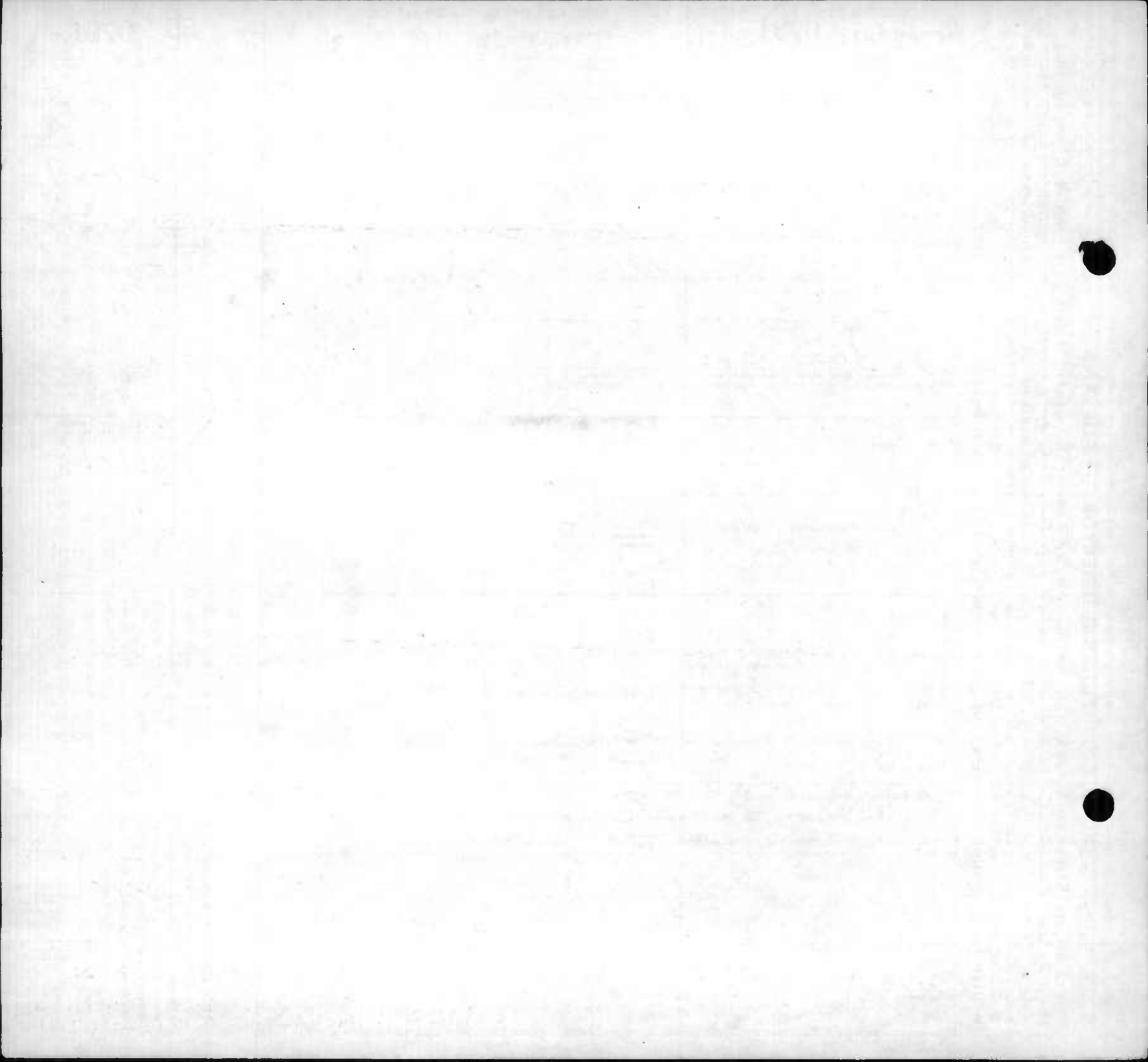


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

BIRTH NO. 65-0791		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65-0791	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) MICHELLE LYNN YODER			22 JAN 65 5:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE, M.D.			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6844 STURBRIDGE DR. #14		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 19 JAN 65	9. AGE (In years last birthday) 3	If Under 1 Yr. Months: Days: Hours: Min. 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DONALD YODER			14. MOTHER'S MAIDEN NAME NANCY HUMPSHIRE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	17. INFORMANT ADDRESS HOSPITAL RECORD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURITY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 3 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 21 Jan 1965 to 22 Jan 1965, that (I) (we) last saw the deceased alive on 21 Jan 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Russell J. Bunai				23B. DATE SIGNED 22 Jan 65	
23C. PHYSICIAN'S NAME (Type) RUSSELL J. BUNAI		23D. ADDRESS University Hospital Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 23 65		24C. NAME OF CEMETERY or CREMATORY RIVERVIEW	
24D. LOCATION LANCASTER, PENN.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Wm. J. Tickner & Sons, North & Pa. Aves. Balto. Md 21217	



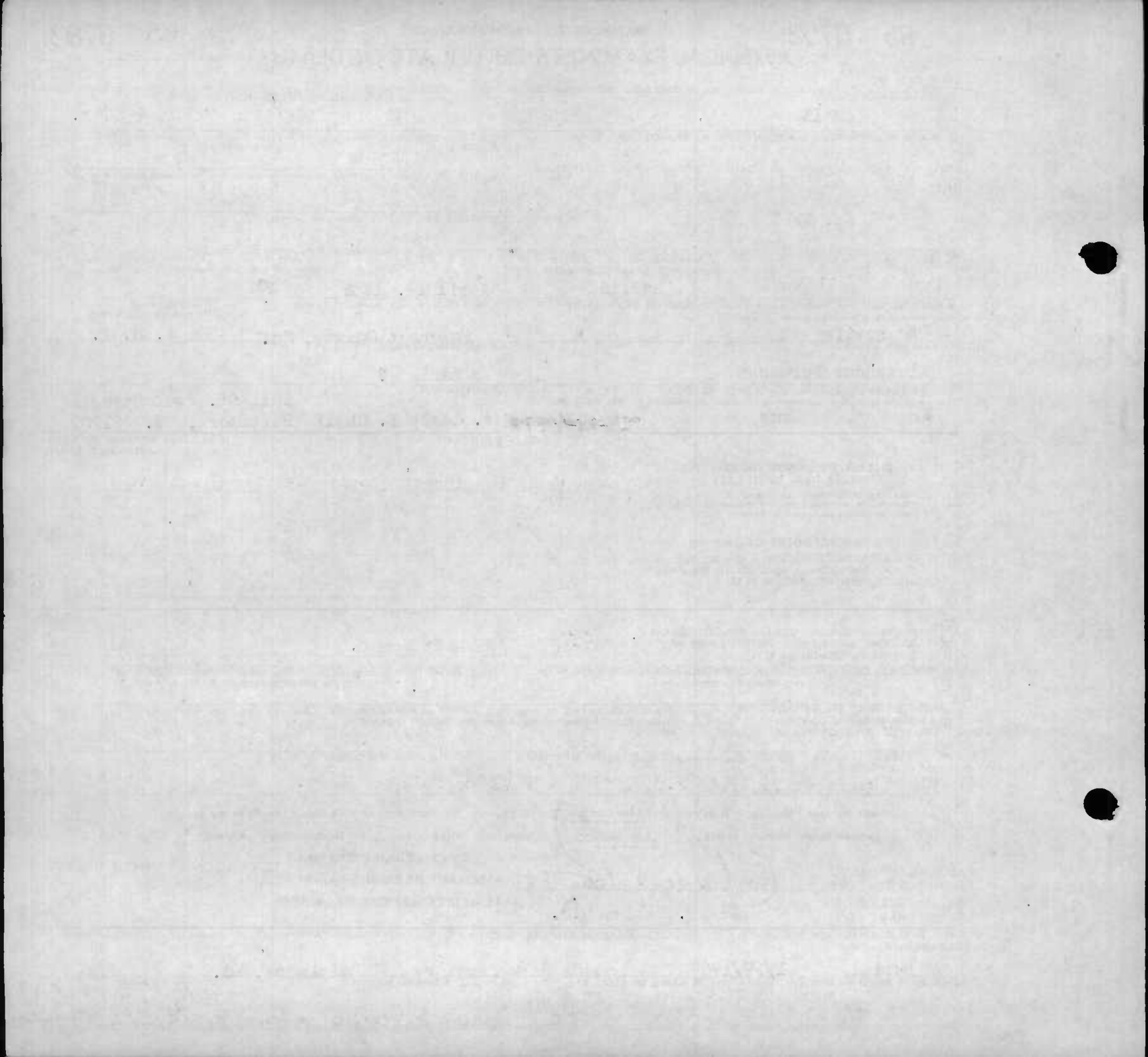
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65 0792

BALTIMORE CITY HEALTH DEPARTMENT

65 0792

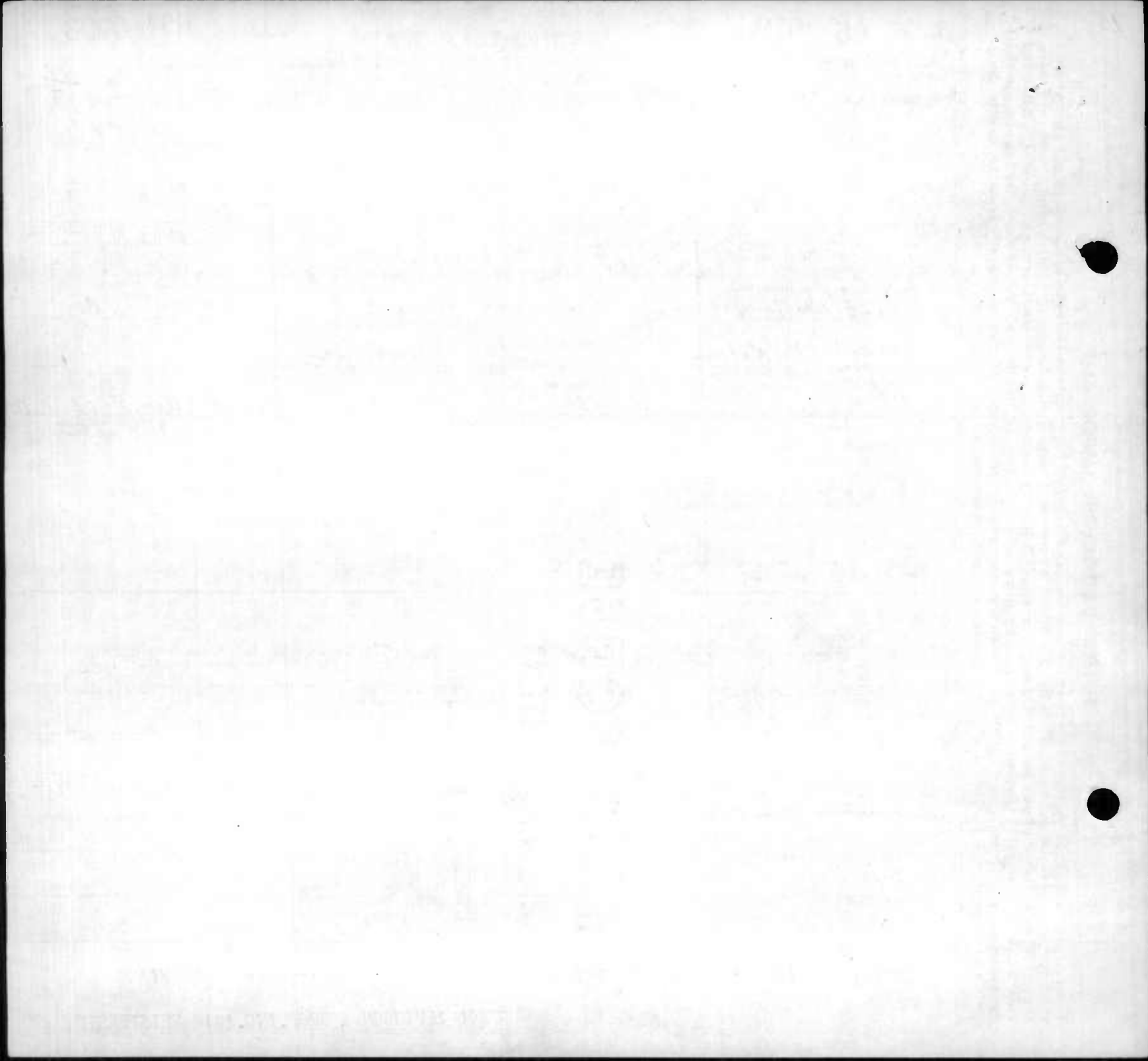
BIRTH NO. 65 0792				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print) ANNIE E. CHELF				2. DATE AND HOUR PRONOUNCED DEAD January 21, 1965 1:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
1811 St. Paul Street				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-05			
				D. STREET ADDRESS (If rural, give location) 1811 St. Paul Street 2			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 12, 1884	9. AGE (In years last birthday) 80	10. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Somerset County, Md.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Alexander Furness				
14. MOTHER'S MAIDEN NAME Maria ?			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None				
16. SOCIAL SECURITY NO. 211-24-6097			17. INFORMANT Mr. James I. Chelf Baltimore, Md. 21202				
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Arteriosclerotic Cardiovascular Disease. DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Fracture of Left Femur.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1811 St. Paul Street			
21D. TIME OF INJURY (APPROX.) December 25, 1964 P.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall on floor.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/21/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/25/1965		23C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR Wm. J. Johnson & Sons		24D. ADDRESS Baltimore, Md. 17 North & Pa. Avenues	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

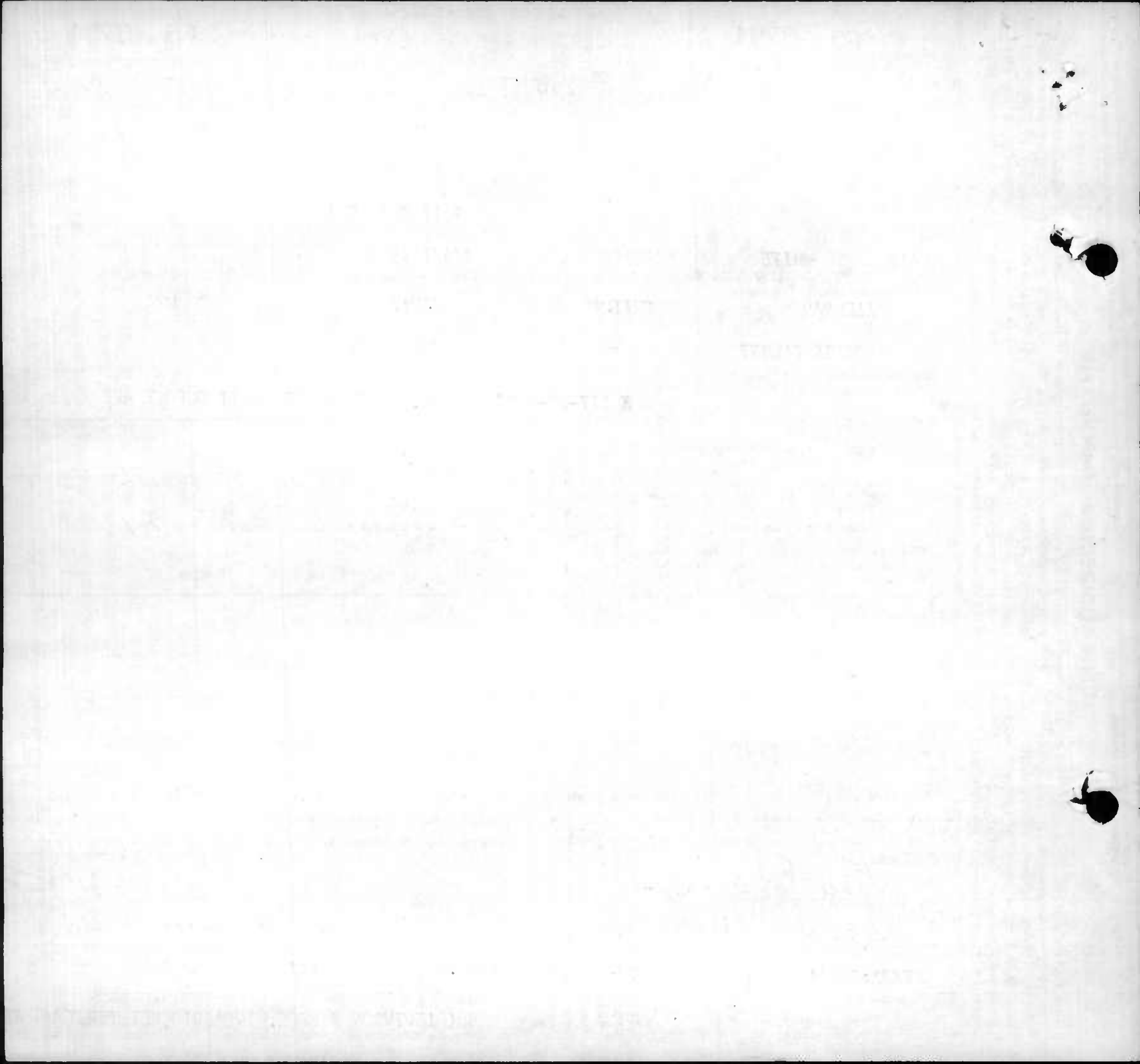
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 0793					CERTIFICATE OF DEATH					Registered No. 65 0793									
M.E. CASE NO.										2. DATE AND HOUR OF DEATH									
1. NAME OF DECEASED (Type or Print) <i>Hackerman, Sophie</i>										Jan 21, 1965 1:15 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i>										A. STATE <i>Maryland</i> B. COUNTY <i>15-11</i>									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>									
										D. STREET ADDRESS (If rural, give location) <i>3506 Ellamont Rd.</i>									
5. SEX <i>FEMALE</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>6/30/1885</i>		9. AGE (In years last birthday) <i>79</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired (Housewife)</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>AT Home</i>				11. BIRTHPLACE (State or foreign country) <i>Russia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Israel Margolius</i>										14. MOTHER'S MAIDEN NAME <i>unknown</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT ADDRESS <i>Dr. Schreiber, 3506 Ellamont Rd. Balto.</i>													
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <i>Congestive Heart Failure</i> DUE TO (B) <i>acute myocardial infarction</i> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>Yes</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <i>1:15 AM Jan 20</i> 19 <i>65</i> to <i>1:15 AM Jan 21</i> 19 <i>65</i> . that (I) (we) last saw the deceased alive on <i>1:15 AM Jan 21</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Ryo Rak Lee</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type) <i>Ryo Rak Lee</i>										23D. ADDRESS M.D. <i>Franklin Square Hosp.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>1/22/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>HEBREW FRIENDSHIP</i>				24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Farley</i>				25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC.</i>				ADDRESS <i>6010 REISTERSTOWN RD</i>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 65 0794	
BIRTH NO. 65 0794		M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) HYMAN EVNITZ						2. DATE AND HOUR OF DEATH JANUARY 21/65 12³⁰ A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-16					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
						D. STREET ADDRESS (If rural, give location) 3011 DUPONT AVE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED		8. DATE OF BIRTH 4/6/1913		9. AGE (In years last birthday) 51		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10B. KIND OF BUSINESS OR INDUSTRY FURNITURE		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS EVNITZ						14. MOTHER'S MAIDEN NAME DORA BART					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. X 217-09-3671		17. INFORMANT ADDRESS MRS. ALMA EVNITZ 3011 DUPONT AVE					
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH 24 years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						ARTERIOSCLEROTIC HEART DISEASE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from JUNE 1963 to JAN 21 1965 , that (1) (we) last saw the deceased alive on JAN 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Leon E. Kassel						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED JAN 21, 1965		
23C. PHYSICIAN'S NAME (Type) LEON E. KASSEL						23D. ADDRESS M.D. 3501 St Paul St, Bkto 18, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/22/65		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMINO (ARLINGTON)				24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC' 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0795</u>	
BIRTH NO. <u>65 0795</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>RAE BERMAN</u>		2. DATE AND HOUR OF DEATH <u>1-22-65</u> <u>4:45 AM</u> <u>4:45 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>27-20</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4004 TODD'S LANE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>W HITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6-1-96</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MAX SELKOWITZ</u>		14. MOTHER'S MAIDEN NAME <u>IDA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>M.</u>		17. INFORMANT ADDRESS <u>MR. SIDNEY M. BERMAN 3407 JANELLEN DRIVE</u>	
18. <u>175.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Post-operative hemorrhage</u> DUE TO (B) <u>Ovarian Carcinoma</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>1-21-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>OVARIAN CARCINOMA</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> 19 <u>63</u> to <u>1-22</u> 19 <u>65</u> , that (I) (last) last saw the deceased alive on <u>1-22</u> 19 <u>65</u> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (last) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1-22-65</u>	
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/24/65</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH HAMEDOSH HAGODOL</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE</u>		(State) <u>MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>	

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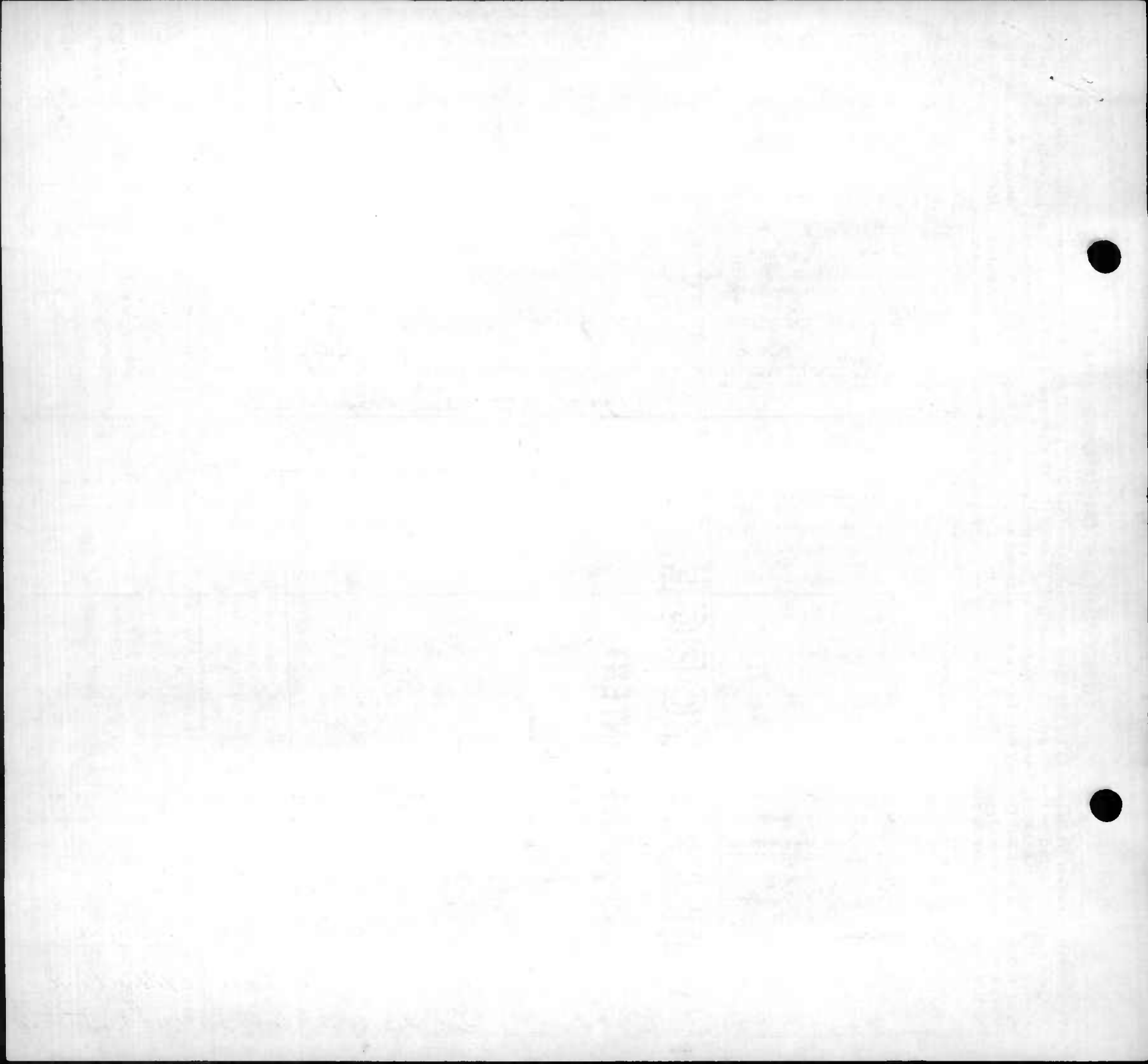
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0796</u>	
BIRTH NO. <u>65 0796</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>STOPAK, AGRAHAM H.</u>		2. DATE AND HOUR OF DEATH <u>1/21/65</u> <u>5:20</u> p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore, Inc.</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>27-26</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>6202 Peace Ave, # 15</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>7/15/198</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesmanager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Match Company</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Stopak</u>				14. MOTHER'S MAIDEN NAME <u>Isly ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>087-05-2326</u>		17. INFORMANT <u>From Hospital Chart</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>527.11 + 199.2</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Chronic obstructive airway disease</u> DUE TO			
				(B) <u>Pulmonary emphysema</u> DUE TO			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD, ? Carcinomatosis</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u> </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>29 December</u> 19 <u>64</u> to <u>21 January</u> 19 <u>65</u> , that the (we) lost saw the deceased alive on <u>21 January</u> 19 <u>65</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Barry M. Cohen</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/21/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>BARRY M. COHEN</u>				23D. ADDRESS <u>Sinai Hospital, Staff Residence</u>			
24A. BURIAL CREMATION, REMOVAL (specify) <u>Burial</u>		24B. DATE <u>1/24/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Jewish Forward</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Del. Levine & Bros Inc. 6010 Reisterstown Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. <u>65 0797</u>						
BIRTH NO. <u>65 0797</u>					M.E. CASE NO. <u>65 0797</u>						
1. NAME OF DECEASED (Type or Print) <u>JACK Lesser</u>					2. DATE AND HOUR OF DEATH <u>1/21/65</u> <u>938</u> P. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S.P.H.S Hospital</u> <u>Balto</u>					A. STATE <u>Balto.</u> B. COUNTY <u>Balto.</u>						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>9 M.D.</u> <u>53-00</u>						
					D. STREET ADDRESS (If rural, give location)						
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED <u>MARRIED</u>		8. DATE OF BIRTH <u>9/18/14</u>		9. AGE (In years last birthday) <u>50</u>			
								If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper Route</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOSEPH LESSER</u>					14. MOTHER'S MAIDEN NAME <u>Bessie ?</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>212 030240</u>					17. INFORMANT'S ADDRESS <u>MRS. BERNICE LESSER 2800 LAURELWOOD CT</u>	
18. <u>190.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Brain Metastases</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Melanoma of the Skin</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH				
					1A) DUE TO		<u>5 WKS</u>				
					1B) DUE TO		<u>4 yrs</u>				
19A. DATE OF OPERATION <u>None</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>11/18/64</u> 19 <u>64</u> to <u>1/21</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>W</u> (did) (did not) view the body after death.											
23A. SIGNATURE <u>Raymond D. Bank</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								23B. DATE SIGNED <u>1/21/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Raymond D. BANK</u>					23D. ADDRESS <u>USPHS Hospital - Balto</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Archie Emanuel City Chm</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>Ad. Linnard & Bros. Inc. 6010 Rustington Rd.</u>			ADDRESS		

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Washing State

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Raymond D. Bank

Raymond D. Bank

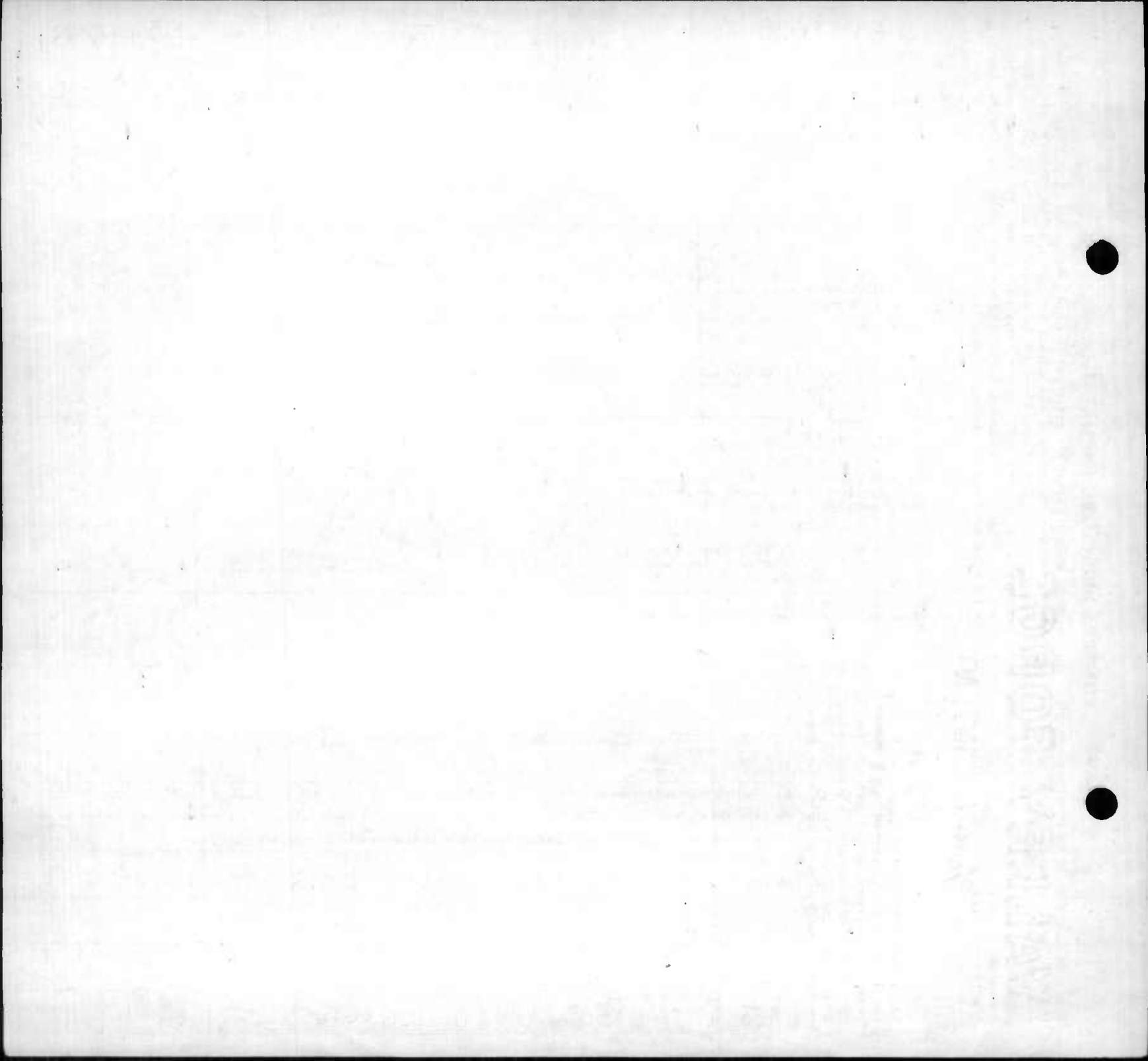
1932

1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

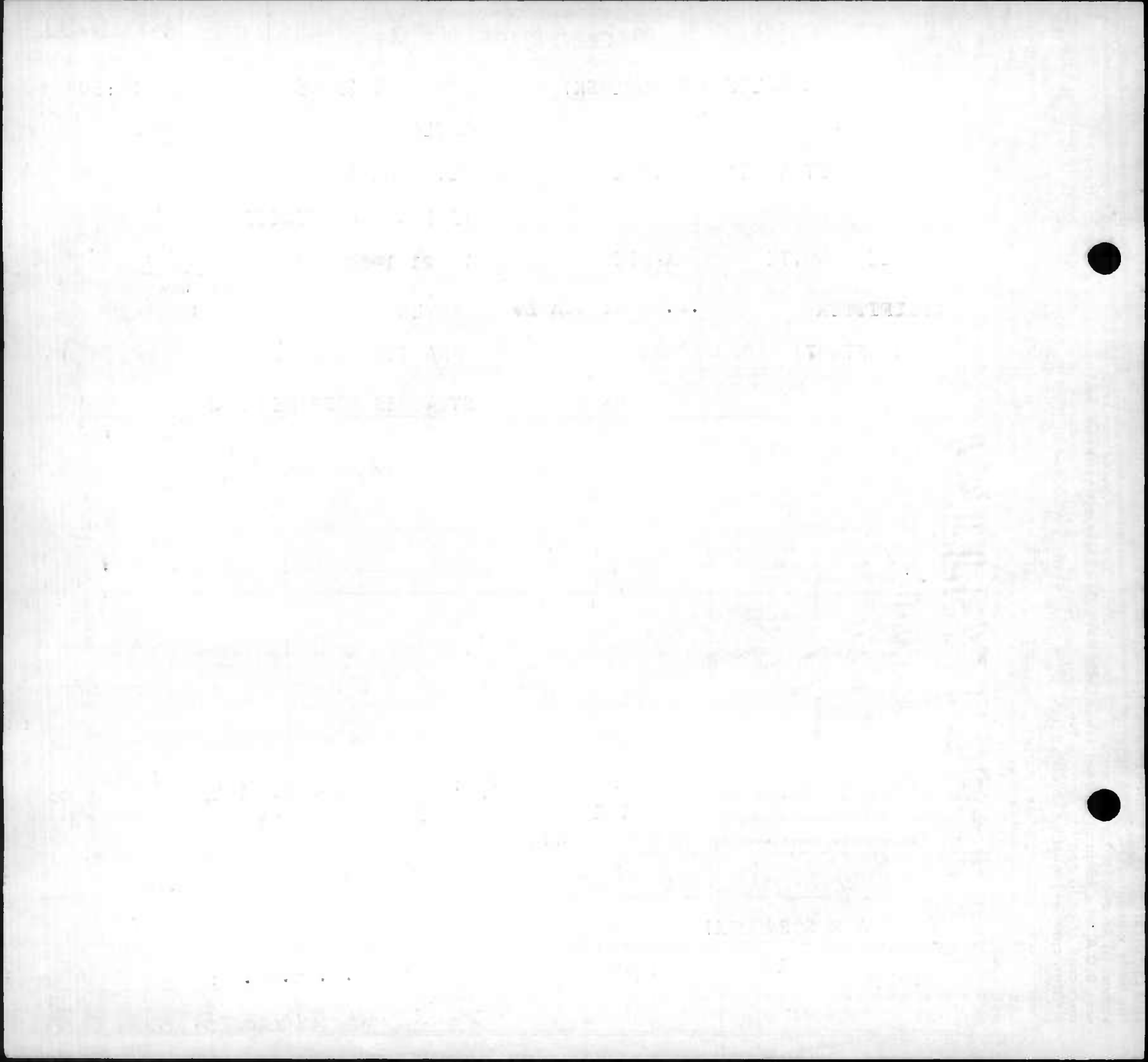
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0798					CERTIFICATE OF DEATH					Registered No. 65 0798				
M.E. CASE NO.										2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) CORA WHITE (Johns, Hilary)										1-23-65 4:15 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP										A. STATE MD B. COUNTY 15-11				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
										D. STREET ADDRESS (If rural, give location) 3613 GRANTLEY RD #15				
5. SEX F		6. RACE C		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W		8. DATE OF BIRTH 5-13-1888		9. AGE (In years last birthday) 76		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10B. KIND OF BUSINESS OR INDUSTRY -					11. BIRTHPLACE (State or foreign country) BALTO., MARYLAND				
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME Rebecca Rollins					12. CITIZEN OF WHAT COUNTRY? USA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 214-18-5056					17. INFORMANT ADDRESS CAROLYN HARP-3613 GRANTLEY RD.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCT										CAUSE OF DEATH (A) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) DUE TO Ca of liver				
										(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 1-13-1965 to 1-23-1965, that (X) (we) last saw the deceased alive on 1-23-1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Aideh Kobler M.D.										23B. DATE SIGNED 1-23-65				
23C. PHYSICIAN'S NAME (Type) Aideh Kobler										23D. ADDRESS Lutheran Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 1-27-65					24C. NAME OF CEMETERY or CREMATORY ARbutus MEMORIAL				
					24D. LOCATION (City, town, or county) (State) ARbutus (Balto. Co.) Md.									
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965					25B. NAME OF REGISTRAR Robert E. Farkas M.D.					25C. FUNERAL DIRECTOR ADDRESS Marshall W. Jones Jr. 1735 Hinford Ave.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

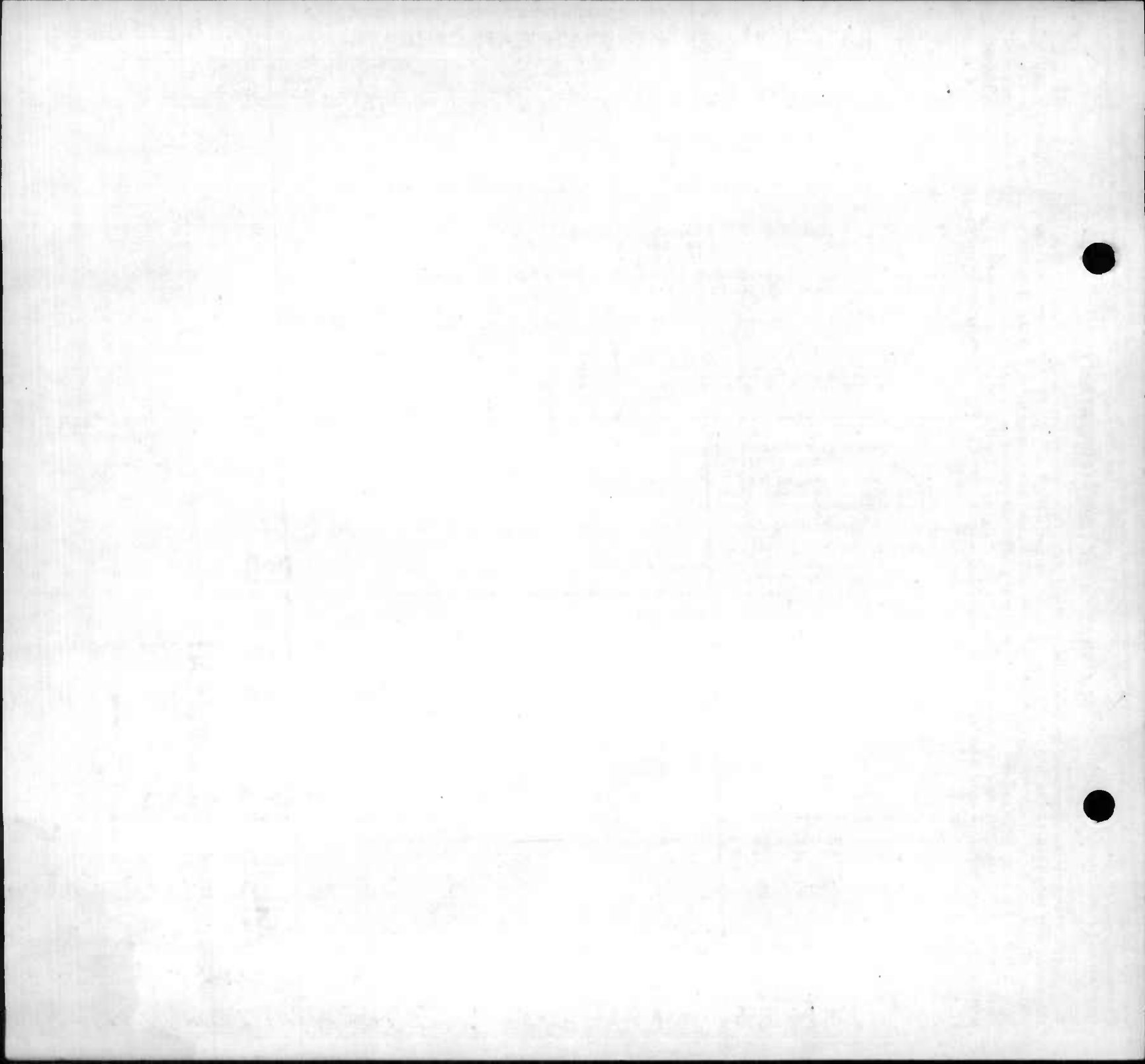
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0799		CERTIFICATE OF DEATH		65 0799	
M.E. CASE NO.		T. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHARLES J WONDOLOSKI		1 23 65 12:30P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		A. STATE MARYLAND		B. COUNTY 25-05	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 26	
		D. STREET ADDRESS (If rural, give location)		1311 CHURCH STREET	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10 21 1900	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPFITTER		10B. KIND OF BUSINESS OR INDUSTRY U.S. COAST GUARD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME CONSTANTI WONDOLOSKI		14. MOTHER'S MAIDEN NAME FRANCES KARWOSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT ST AGNES HOSP RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Myocardial Infarction Post.		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21H. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21I. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21J. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21K. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21L. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 18 1965 to 1 23 1965, that (I) (we) last saw the deceased alive on 1 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (XXX) not view the body after death.		23A. SIGNATURE A.R. Sosnowski		23B. DATE SIGNED 23 Jan 65	
23C. PHYSICIAN'S NAME (Type) A R SOSNOWSKI		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/65		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION A.A.Co.Md.		24E. NAME OF CEMETERY or CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Wm. S. Fialkowski	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0800					CERTIFICATE OF DEATH		Registered No. 65 0800		
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>NOLA E. STEPHANS</i>					2. DATE AND HOUR OF DEATH <i>1-22-65</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>FRANKLIN SQUARE</i>					A. STATE <i>MD</i> B. COUNTY <i>19-02</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>1500 W. Baltimore St.</i>				
5. SEX <i>7</i>	6. RACE <i>w.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Dec 14, 1892</i>	9. AGE (In years lost birthday) <i>72</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W. -</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Edward L. CARROLL</i>			14. MOTHER'S MAIDEN NAME <i>HAURA NAPIER</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT ADDRESS <i>Anna Smith 514 Quail St.</i>				
18. <i>7-20-01</i>			CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) <i>Arteriosclerotic Heart Disease</i>				<i>6 months</i>		
ANTECEDENT CAUSES			(B) DUE TO						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO						
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>January 1964</i> to <i>January 1965</i> , that (I) (we) last saw the deceased alive on <i>Jan 21 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Morris B. Schreiber</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1-23-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>MORRIS B. SCHREIBER</i>					23D. ADDRESS <i>1519 W. Lombard St.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/25/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Western</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Farber</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Witke 4101 Edmondson Ave</i>			



35-87-18 AB 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0801

BIRTH NO. 65 0801

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Albert Gibbons

2. DATE AND HOUR OF DEATH

1-21-65

6:00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6526 Fait Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-16-94

9. AGE (In years
last birthday)

70

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Tugboat

11. BIRTHPLACE (State or foreign country)

Delaware

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Seth Gibbons

14. MOTHER'S MAIDEN NAME

Louisa ?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-093064

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Intestinal Obstruction
DUE TO

22 Days

ANTECEDENT CAUSES

(B) Metastatic Carcinoma of the Colon
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Same

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-30 19 64 to 1-21 19 65
that (I) (we) last saw the deceased alive on 1-21 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

1-21-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/23/65

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

John M. Weber & Sons Inc.

ADDRESS

401 S. Chester St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
J-250

65 0802

BALTIMORE CITY HEALTH DEPARTMENT

65 0802

BIRTH NO. 64-37205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE A. JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1965

9:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

317 N. Schroeder Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

Nov. 18, 1964

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Jackson

14. MOTHER'S MAIDEN NAME

Bernice Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

William Jackson 317 N. Schroeder St.

18. 391.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Interstitial pneumonitis

(A) DUE TO otitis media, purulent, right

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan 22, 1965

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 317 N. Schroeder St.

ADDRESS

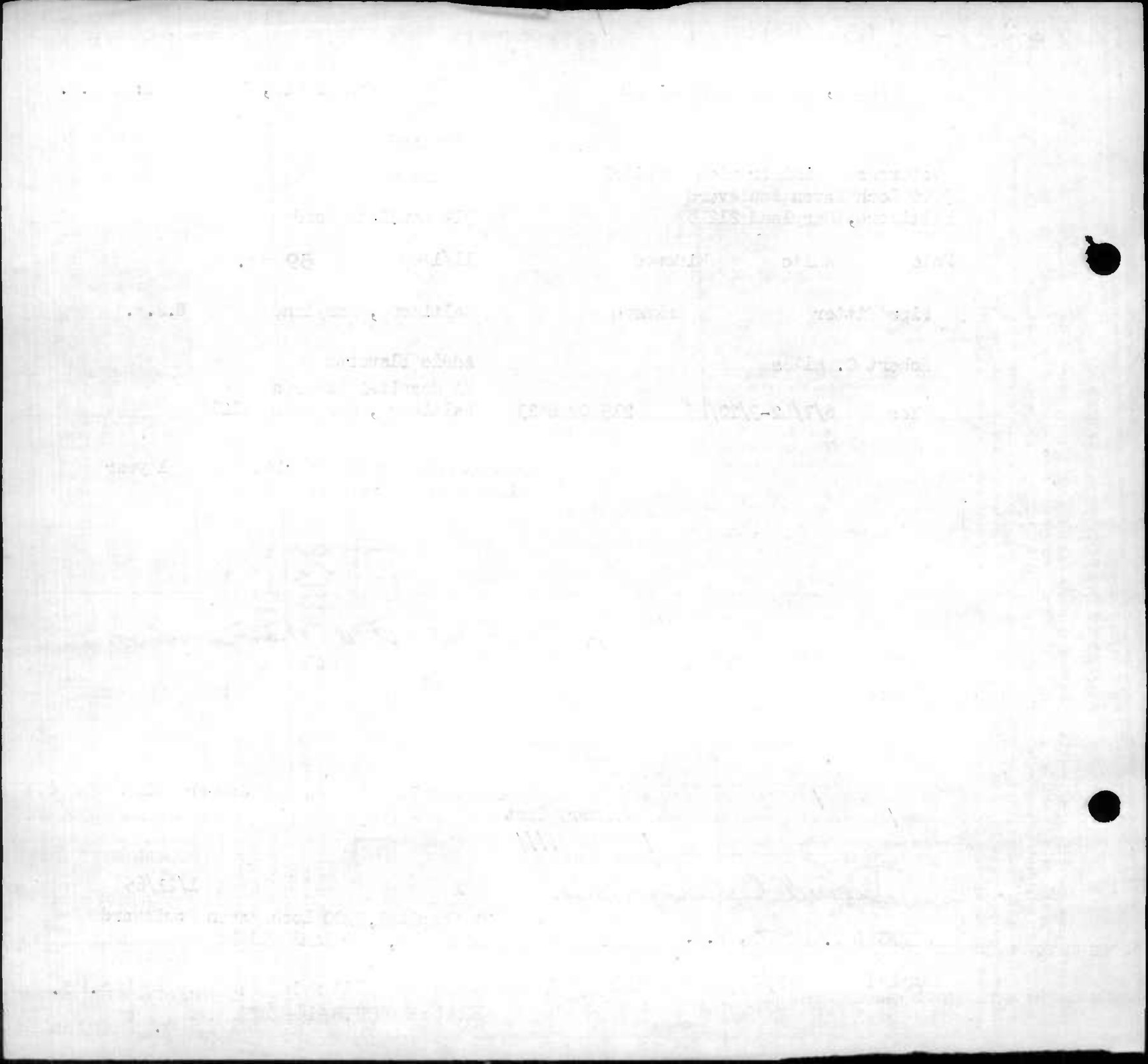
WALLACE & GORING

THE SOUTH

WALLACE & GORING

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

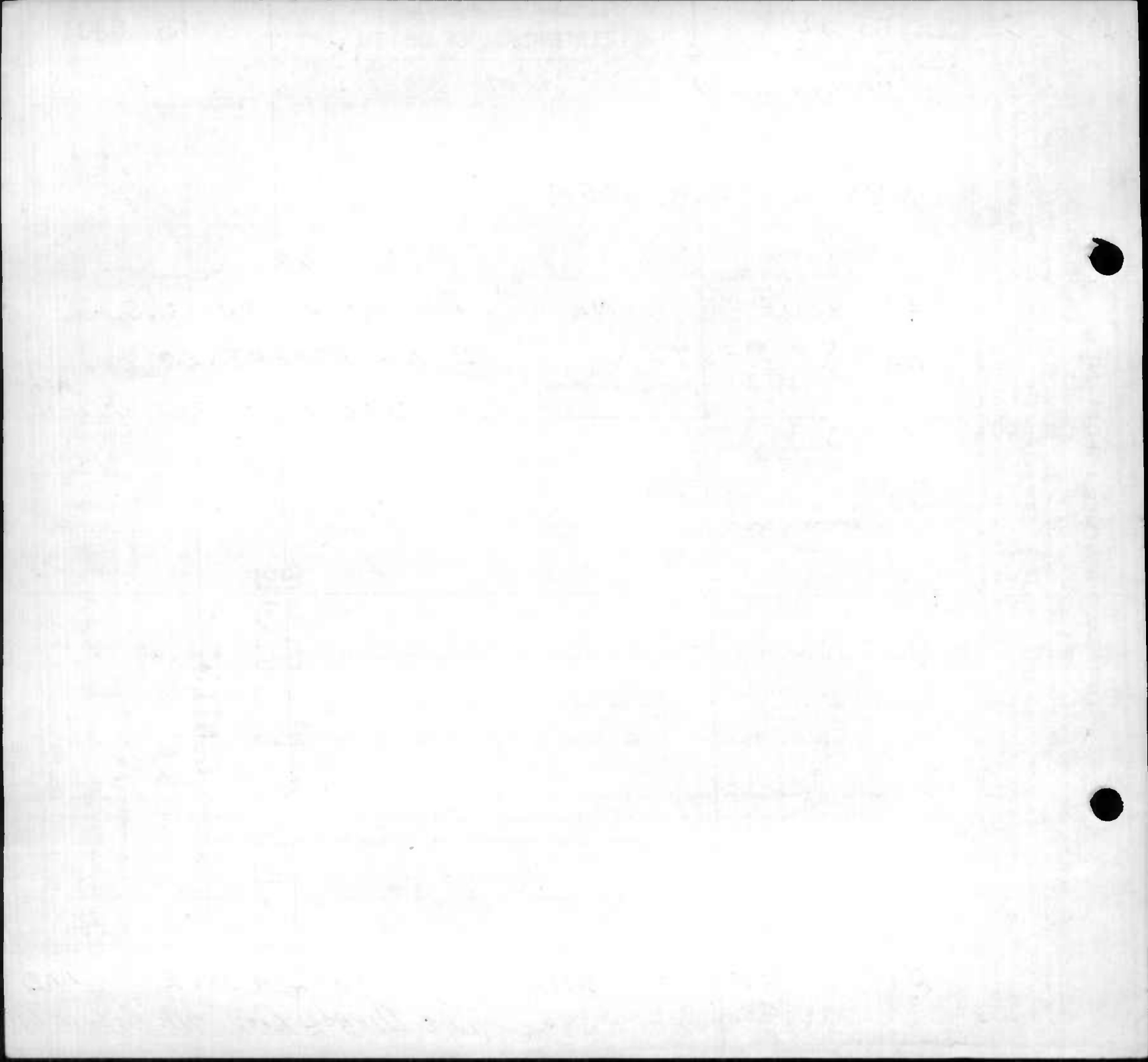
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0803</u>	
BIRTH NO. <u>65 0803</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>January 21, 1965</u> <u>1:00 P.M.</u> M.			
1. NAME OF DECEASED (Type or Print) <u>MILES, ROBERT CHRISTOPHER</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>312 Newfield Road</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/1/05</u>	9. AGE (In years last birthday) <u>59yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert C. Miles</u>		14. MOTHER'S MAIDEN NAME <u>Addie Elsworth</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>8/7/42-9/20/45</u>		16. SOCIAL SECURITY NO. <u>215 09 4823</u>		17. INFORMANT <u>VA Hospital Records</u> <u>Baltimore, Maryland 21218</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>16211</u> <u>CAUSE OF DEATH</u> (A) <u>Bronchogenic Carcinoma with widespread Metastases</u> (B) <u>1 year</u> (C) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. DATE OF OPERATION <u>16211</u>		20. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>ASCVD - Anterolateral M.I.</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yeast.</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>19 64</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>December 7th</u> to <u>January 21st</u> 19 <u>65</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>December 7th</u> 19 <u>64</u> to <u>January 21st</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>January 21st</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel C. Persyn, M.D.</u>				23B. DATE SIGNED <u>1/21/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>DANIEL C. PERSYN, M.D.</u>				23D. ADDRESS <u>VA Hospital, 3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Ritchie Highway Balto. Md.</u>		24E. FUNERAL DIRECTOR <u>KRAUSE FUNERAL HOME</u>		24F. ADDRESS <u>1216 S. Charles St</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>KRAUSE FUNERAL HOME</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0804					CERTIFICATE OF DEATH X					Registered No. 65 0804				
M.E. CASE NO. Catherine					1. NAME OF DECEASED (Type or Print) Catherine O. Petrich					2. DATE AND HOUR OF DEATH 1/21/65 11 26 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Md					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.					D. STREET ADDRESS (If rural, give location) 1202 Register Av.									
5. SEX female		6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 8/7/02		9. AGE (In years last birthday) 62		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME					10B. KIND OF BUSINESS OR INDUSTRY NONE					11. BIRTHPLACE (State or foreign country) BALTIMORE MD				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME HENRY REUTER					14. MOTHER'S MAIDEN NAME LONA PFOERTNER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS FRED. O. PETRICH 1202 REGISTER AVE				
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) Coronary thrombosis 1 cr (B) Diabetes Mellitus (C)					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1/21/65 19 65 to 1/21 19 65 that (I) (we) last saw the deceased alive on 1/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE [Signature] M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 1/21/65				
23C. PHYSICIAN'S NAME (Type) Ingeborg W. FROMM					23D. ADDRESS M.D. 1123 St. Paul Street									
24A. BURIAL/CREMATION REMOVAL (Specify) BURIAL					24B. DATE 1/25/65					24C. NAME OF CEMETERY OR CREMATORY PARKWOOD				
24D. LOCATION TAYLOR AVE MD					24E. CITY, TOWN, OR COUNTY					24F. STATE				
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965					25B. NAME OF REGISTRAR Robert E. [Signature]					25C. FUNERAL DIRECTOR'S ADDRESS The Dipfel Bros 7110 BELAIR RD.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0805</u>	
BIRTH NO. <u>65 0805</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Sister Josephine Sellow (Edna Josephine)</u>			
2. DATE AND HOUR OF DEATH <u>Jan. 21, 1965</u> <u>4:56</u> A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>1000 Forest Hill Road</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Villa St. Michael</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Frederick</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Emmitsburg</u> D. STREET ADDRESS (If rural, give location) <u>St. Joseph's Provincial House</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 25, 1894</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Religious Sister</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bellerica, Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lewis L. Sellow -born Provincetown, Mass.</u>		14. MOTHER'S MAIDEN NAME <u>Eliz. M. Parks -born Arlington, Mass.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>Sister Mary Louise, 1000 Forest Hill Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>421.41</u> <u>Myocardial decompensation</u>		CAUSE OF DEATH (A) DUE TO <u>Endocarditis</u> (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>12 years</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 16, 1960</u> to <u>Jan. 21, 1965</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stewart & Mowen</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>Jan. 21, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stewart & Mowen</u>		23D. ADDRESS M.D. <u>3326 Frederick Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-23-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Joseph's Cem. Emmitsburg-Fredk. Co. Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Emmitsburg-Fredk. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Stewart & Mowen - 108 W. North Ave. -</u>			

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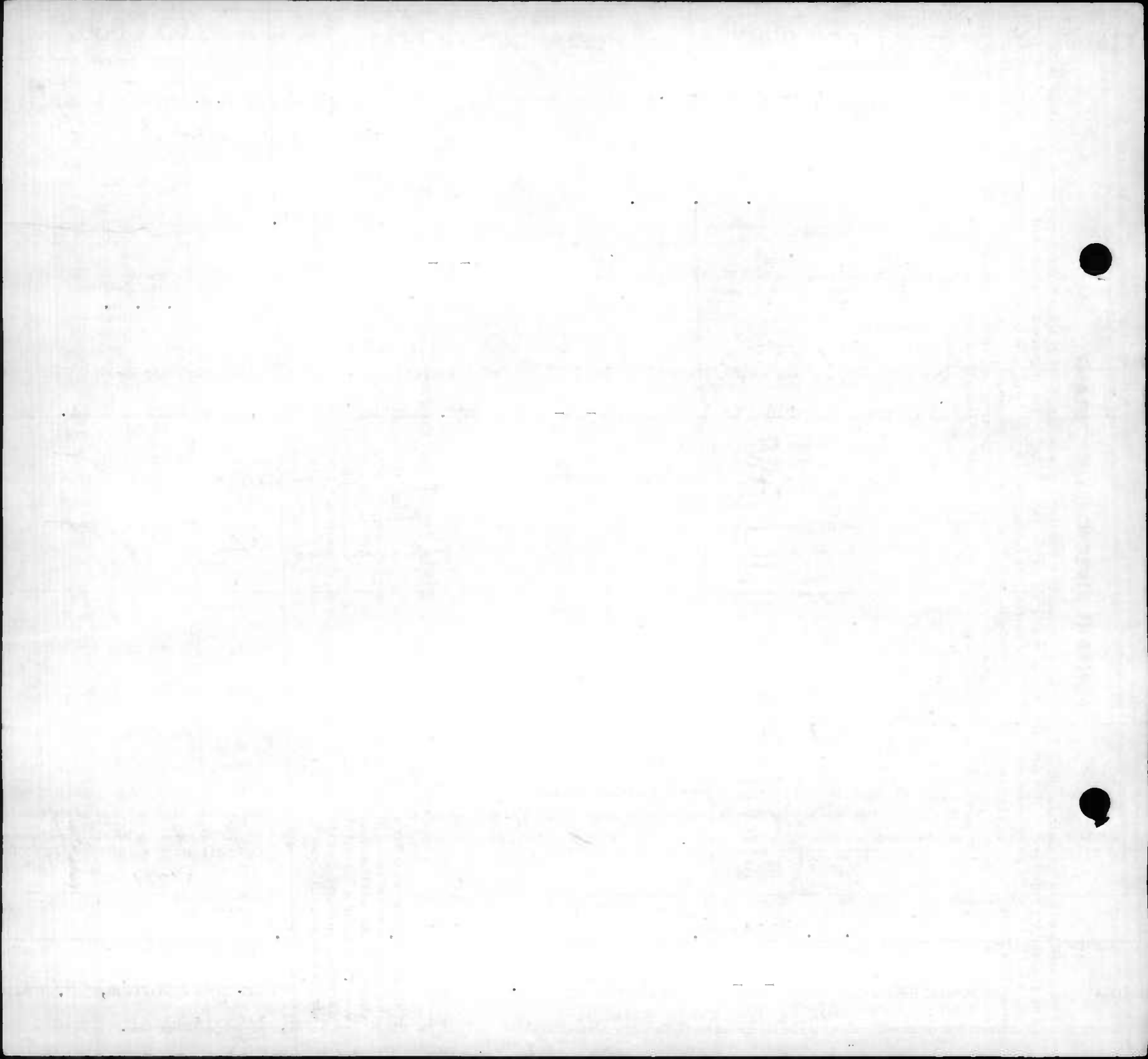
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

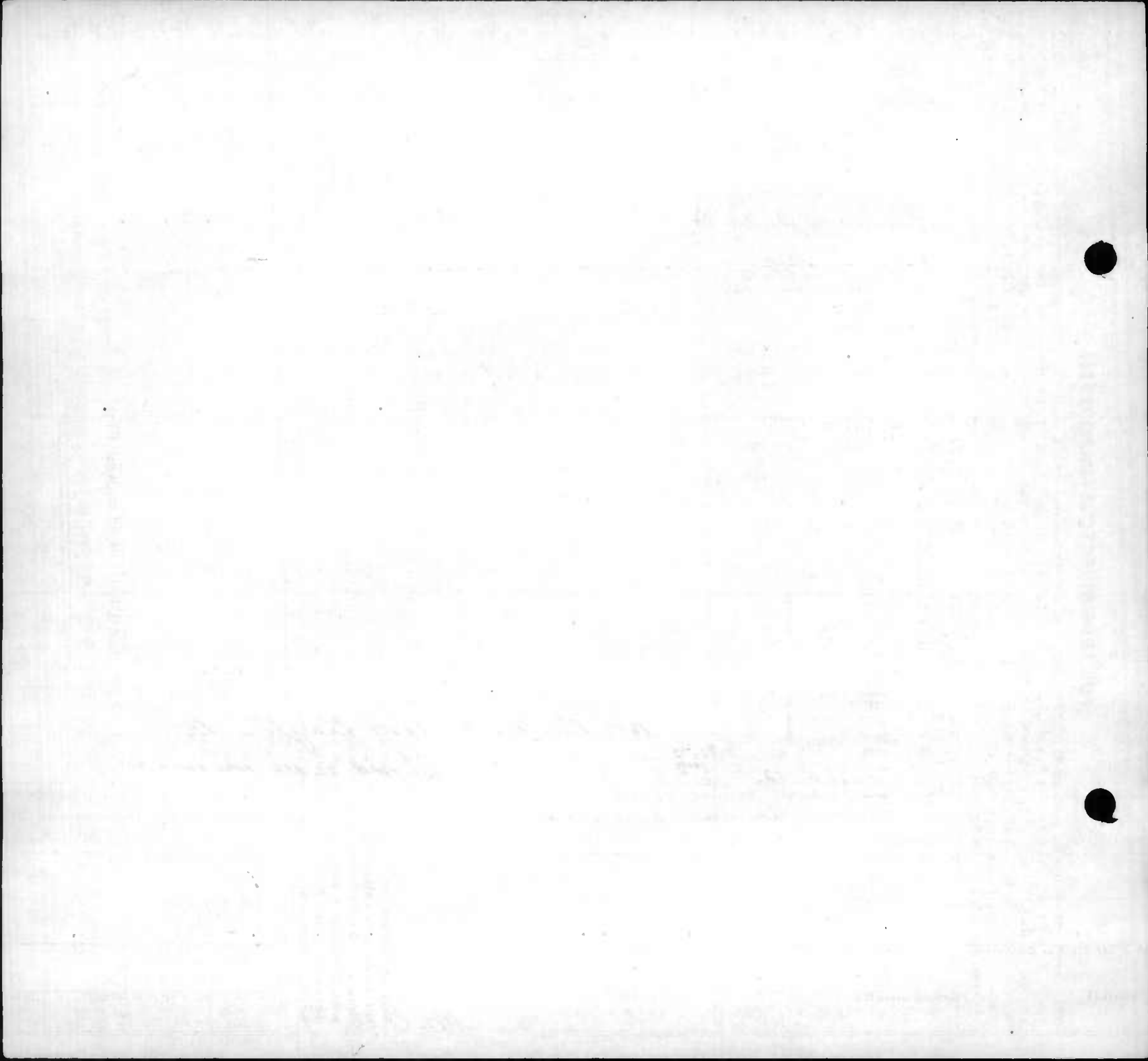
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0807	
BIRTH NO. 65 0807		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Kraft, Herman C.</u>		2. DATE AND HOUR OF DEATH <u>1/21/65 11 p.m.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Balto. Gen. Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2302</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1224 Marshall St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12-16-02</u>	9. AGE (In years last birthday) <u>62</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Kraft</u>		
14. MOTHER'S MAIDEN NAME <u>Ella Hoffman</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes World War 1</u>		16. SOCIAL SECURITY NO. <u>220-30-2668</u>		
17. INFORMANT <u>Mrs. Marguerite Kraft, 1224 Marshall St.</u>			ADDRESS				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction - Syst</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis - Generalized 10 yrs</u> <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 to <u>1965</u> 19, that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>OK 1001 51584</u>							
23A. SIGNATURE <u>E. S. Ellison</u> M.D.				23B. DATE SIGNED <u>1/22/65</u>		23C. PHYSICIAN'S NAME (Type) <u>E. S. Ellison</u> M.D.	
23D. ADDRESS <u>107 E. West St. #30</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1-25-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. Glen Burnie, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Flynn</u>		25C. FUNERAL DIRECTOR <u>Flynn & Fleming, 1422 Light St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

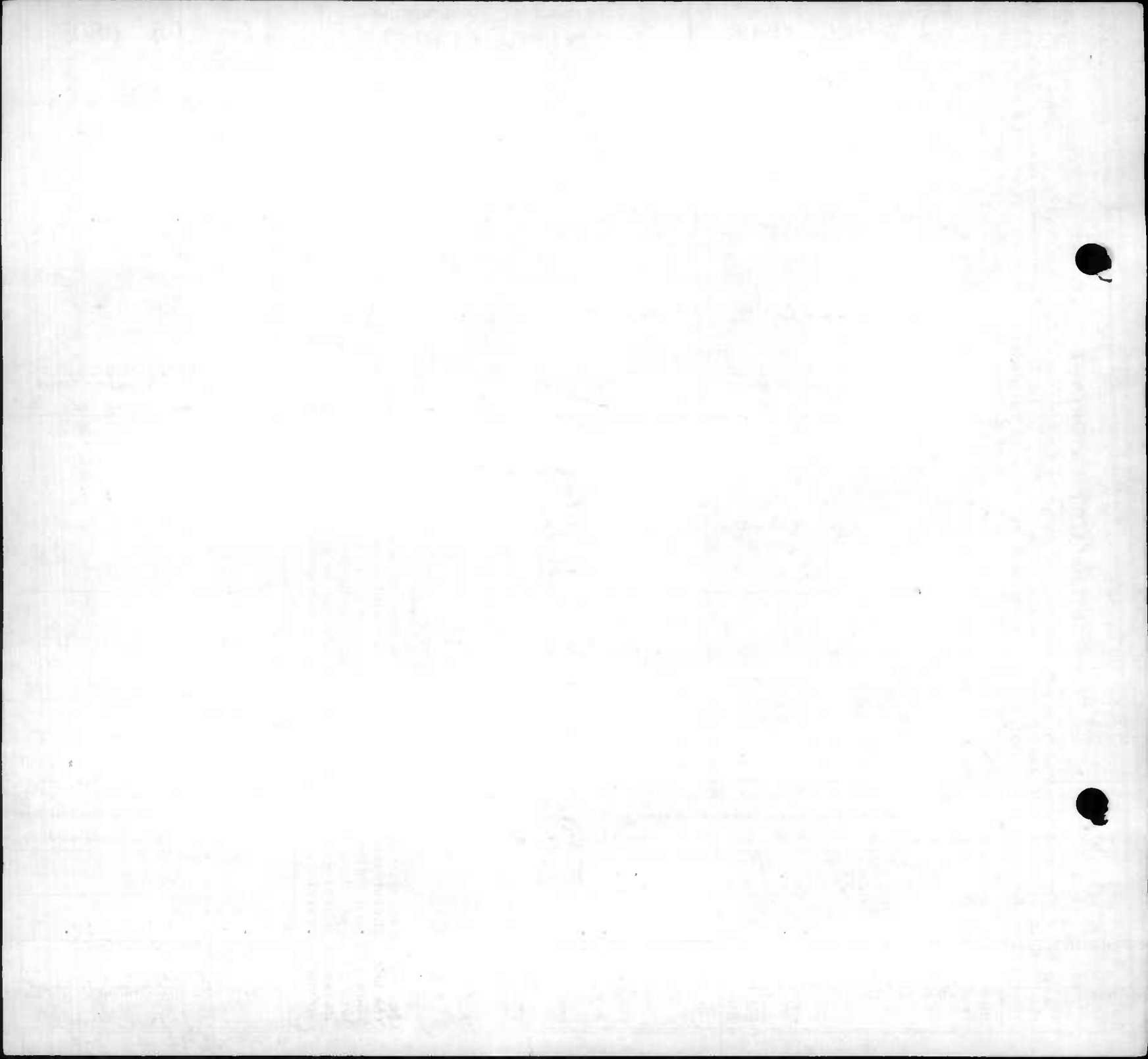
BIRTH NO. 65 0806				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0806	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				John Willett		1/19/65 11:00 a. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE			
						Maryland			
South Baltimore General Hospital						C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
						Baltimore			
D. STREET ADDRESS (If rural, give location)						1607 Clayton Court Balto. 25, Md.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Min.	
Male	White	Married		9 28 1909	55 55				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Chauffeur				Trucking		Virginia		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
John J. Willett						Helen Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				213 05 1878		Lillian W. Willett 1607 Clayton Ct. 0			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<p>① Commotated fracture of the right humerus</p> <p>② Commotated sub and intertrochanteric fracture of right femur</p> <p>③ Cirrhosis of the liver</p> <p>④ Congestive failure?</p>						<p>11/20/65</p> <p>CERTIFICATION APPROVED</p> <p>CHIEF OR ASST. MEDICAL EXAMINER</p>			
19. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2								Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
				1607 Clayton Ct		1607 Clayton Ct 24-04			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
1 12 5:50 pm				While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		slipped on ice in rear alley			
22. I certify that (X) (this hospital) attended the deceased from 1/15/65 to 1/19/65, that (X) (we) lost saw the deceased alive on 1/10/65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Chung K. Bae M.D.						1/19/65			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
CHUNG K. BAE, M.D.						South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		1/22/65		Glen Haven		ANNE ARUNDEL County			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 25 1965		Robert E. Fisher, M.D.		McCullys Funeral Homes		130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0808	
BIRTH NO. 65 0808		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lonie Newsome		2. DATE AND HOUR OF DEATH 1/21/65 8:17 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1143 Wicomico Street Balto. 30, Md.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3/17/00	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?		13. FATHER'S NAME Strickland		14. MOTHER'S MAIDEN NAME Betty ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 782,41		17. INFORMANT David Newsome 133 Blenheim Ave. Balt.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heart Failure				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 1/6/65 19 to 1/21/65 19, that (A) (we) last saw the deceased alive on 1/21/65 19 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M.W. Kilchenstein						23B. DATE SIGNED 1/22/65	
23C. PHYSICIAN'S NAME (Type) M.W. KILCHENSTEIN, M.D.				23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glen Haven, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John J. Brown, Inc. 901 Hollins St. Balto. 23, Md.			



BIRTH NO. 65 0809		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0809	
M.E. CASE NO. 59340					
1. NAME OF DECEASED (Type or Print) ROSSIE GRANT C.			2. DATE AND HOUR PRONOUNCED DEAD January 17, 1965 4:35 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital DOA			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1956 Walbrook Avenue		
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10-7-1885	9. AGE (In years last birthday) 79	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minister		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Woodland, N.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Junius Grant			14. MOTHER'S MAIDEN NAME Julia M.N. Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Dorothy Grant Same		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE m. WORK AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Rudiger Breitenecker</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-17-65					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-21-65		23C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Cemetery	
23D. LOCATION (City, town, or county) (State) Baltimore Md.					
24A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.		24C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monmouth St.	

ALBANY POLICE

ALBANY POLICE DEPARTMENT
ALBANY, N.Y.

W. 523

65 0810

BALTIMORE CITY HEALTH DEPARTMENT

65 0810

BIRTH NO.		M.E. CASE NO. 59364		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.	
1. NAME OF DECEASED (Type or Print) MAMIE WINSTON				2. DATE AND HOUR PRONOUNCED DEAD January 19, 1965 5:10 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. JOSEPH HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1547 Homestead Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Sept. 28, 1920	9. AGE (In years last birthday) 44	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Charles Hasten			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Lloyd Winston		ADDRESS Same
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
(A) Bronchopneumonia		(B) Hepatic coma		(C) cirrhosis of liver	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John E. Adams EXAMINER'S NAME (Type)		M.D. John E. Adams, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-19-65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-23-65		23C. NAME of CEMETERY or CREMATORY Archutus Mem. Pk	
23D. LOCATION (City, town, or county) (State) Baltimore Md.		24A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			
24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Arlington S. Phillips			
24D. ADDRESS 1727 D. Monroe					

VALLEY
OFFICE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0811	
BIRTH NO. 65 0811				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MC COY SILVER		January 20, 1965 2:45 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY 13-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2412 EUTAW PLACE		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 7-19-20	9. AGE (In years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME WALTER SILVER			14. MOTHER'S MAIDEN NAME LINZY LYNCH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 242-14-9795		17. INFORMANT Ethel Silver 2701 Ulman Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I PERITONITIS			CAUSE OF DEATH (A) DUE TO PERITONITIS		INTERVAL BETWEEN ONSET AND DEATH 15d.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) DUE TO PERITONITIS		16 yrs.
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/19 1965 to 1/20 1965, that (I) (we) last saw the deceased alive on January 20, 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert B. Blackman			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/20/65
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) MD.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Arlington Phillips		ADDRESS 1727 N. Monmouth			

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THE UNIVERSITY OF CHICAGO

1922

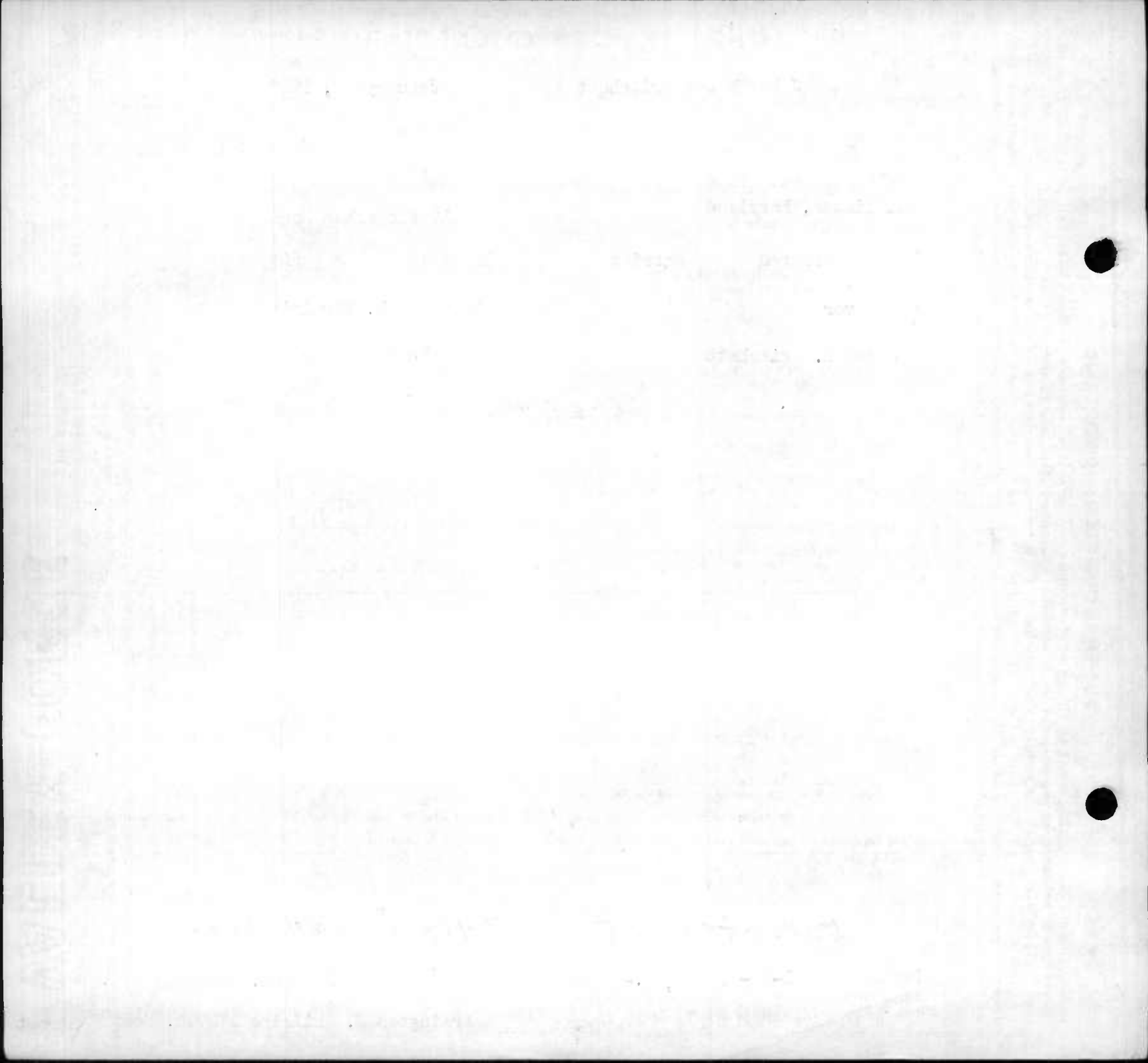
THE UNIVERSITY OF CHICAGO

1922

FUNERAL DIRECTOR: IMPORTANT

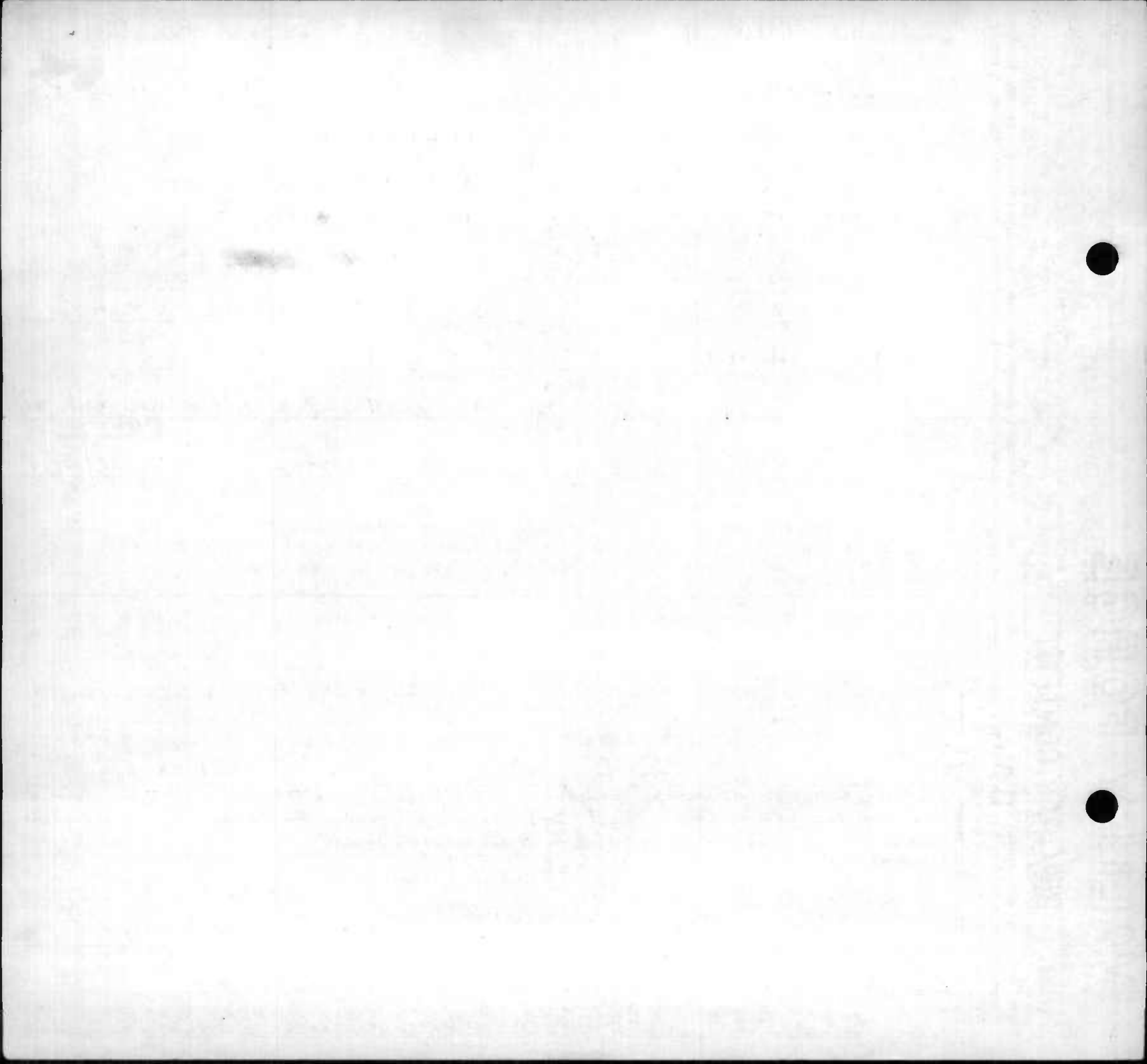
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0812			
BIRTH NO. 65 0812									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		John Thomas Pritchett				2. DATE AND HOUR OF DEATH January 20, 1965 5:15 P.M.			
3. PLACE OF DEATH (IN BALTIMORE, MARYLAND)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland				B. COUNTY 16-08			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3919 Flowerton Road Baltimore, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 3919 Flowerton Road			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12/14/14	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME James E. Pritchett				14. MOTHER'S MAIDEN NAME Nancy Greene					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07741		17. INFORMANT Ashia Pritchett		ADDRESS Same			
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma, esophagus unknown (B) Arteriosclerotic Heart Dis. unknown (C)				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Vascular Dis. unknown							
		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/19 1965 to 1/20 1965, that (I) (we) last saw the deceased alive on 1/19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Stewart				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/20/65			
23C. PHYSICIAN'S NAME (Type) J.W. Stewart				23D. ADDRESS M.D. 3414 Duvall Ave.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-65		24C. NAME OF CEMETERY or CREMATORY Mt.- Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monro ^{oe} Street					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

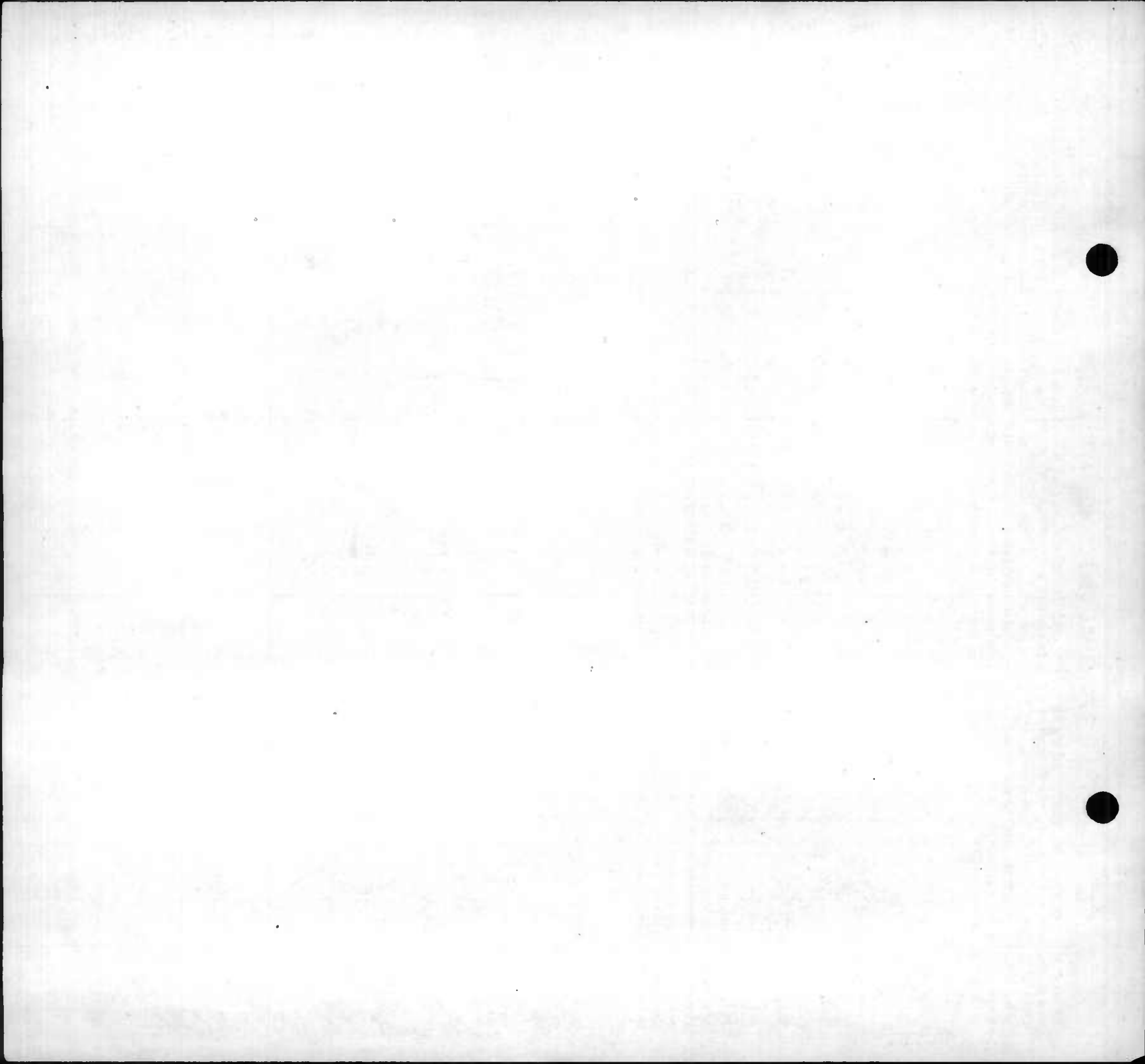
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0813	
BIRTH NO. 65 0813		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDWARD HILL		2. DATE AND HOUR OF DEATH JAN 22, 1965 4.30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY X		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-01	
FULL NAME OF HOSPITAL OR INSTITUTION Geo. WASHINGTON CARVER Nursing Home 607 PENNSYLVANIA AVE BALTIMORE, MARYLAND		D. STREET ADDRESS (If rural, give location) 1507 Presser Ct			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-26-1904	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME DAN HILL		14. MOTHER'S MAIDEN NAME Mattie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 416-01-7805		17. INFORMANT CHARLES 687	
				ADDRESS 607 PENNSYLVANIA AVE BALTO, MD	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebrovascular accident (B) hypertensive arteriosclerosis (C) cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 10/15/64	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/15 19 64 to 1/22 19 65 , that (I) (we) last saw the deceased alive on 1/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Mac Murchy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) 500 J.N. MAC MURCHY		23D. ADDRESS 500 E Madison St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-65		24C. NAME of CEMETERY or CREMATORY Trinitas Mem PK Trinitas, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
		25C. FUNERAL DIRECTOR Stony A. K. 1518 N. Calhoun St		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

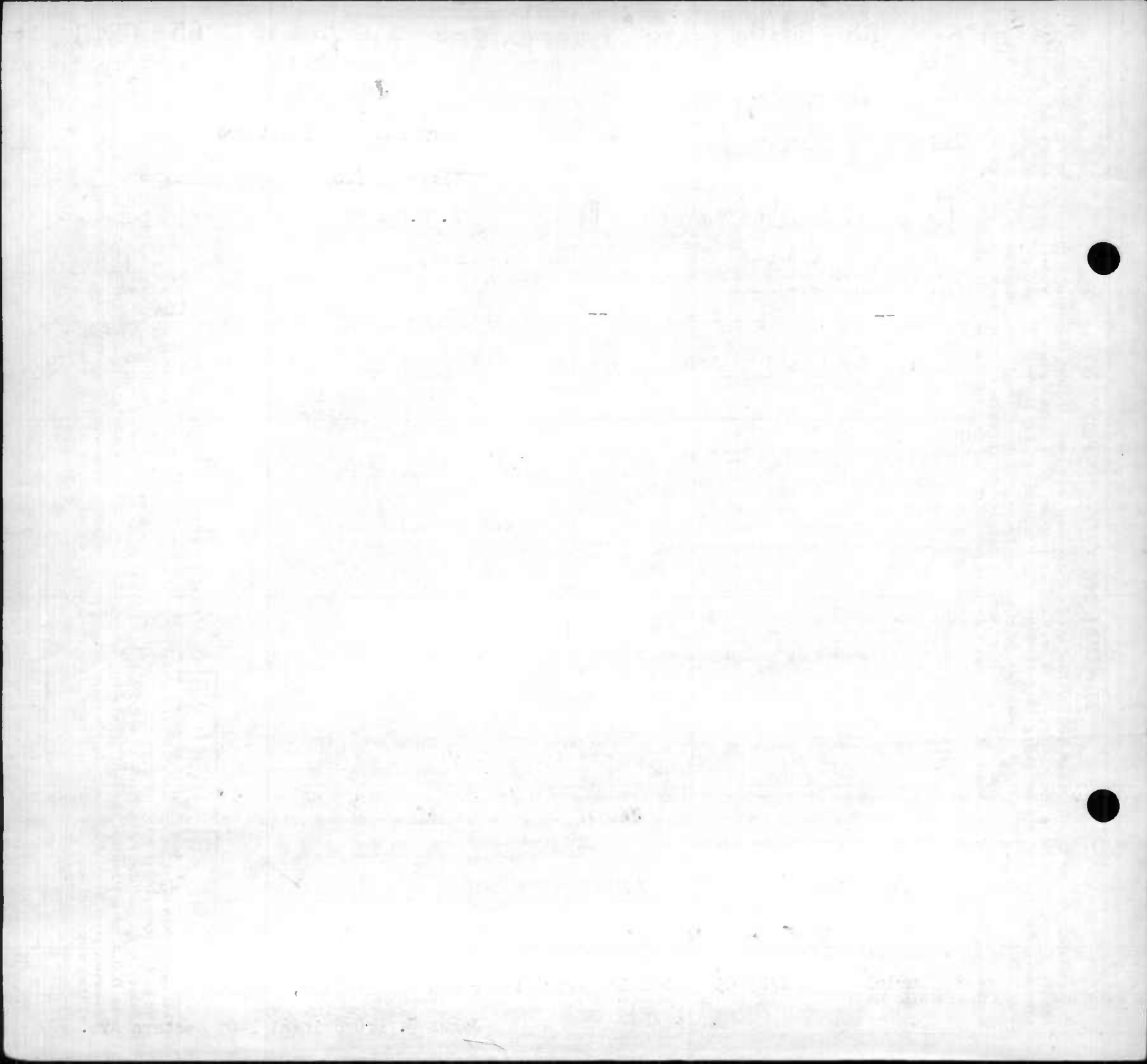
BIRTH NO. 65 0814		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0814	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Annie Burrell (Bell)			2. DATE AND HOUR OF DEATH 1-21-65 6:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division St. Baltimore, Maryland			A. STATE Maryland B. COUNTY 1602 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1113 N. Parrish St.		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-25-1902	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William Kidd		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 217-18-9913			17. INFORMANT Elizabeth Burrell 2923 Belmont Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 172X I			CAUSE OF DEATH (A) Electrolytic Imbalance (B) Endometrial Cancer (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH Not Known		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 21 January 1965 to 21 January 1965 , that (I) (we) last saw the deceased alive on 21 January 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Armstead			23B. DATE SIGNED 21 January 1965		
23C. PHYSICIAN'S NAME (Type) John Armstead			23D. ADDRESS 15141 Division St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Balto. Natl. Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR George H. Klen 1548 N. Calhoun St		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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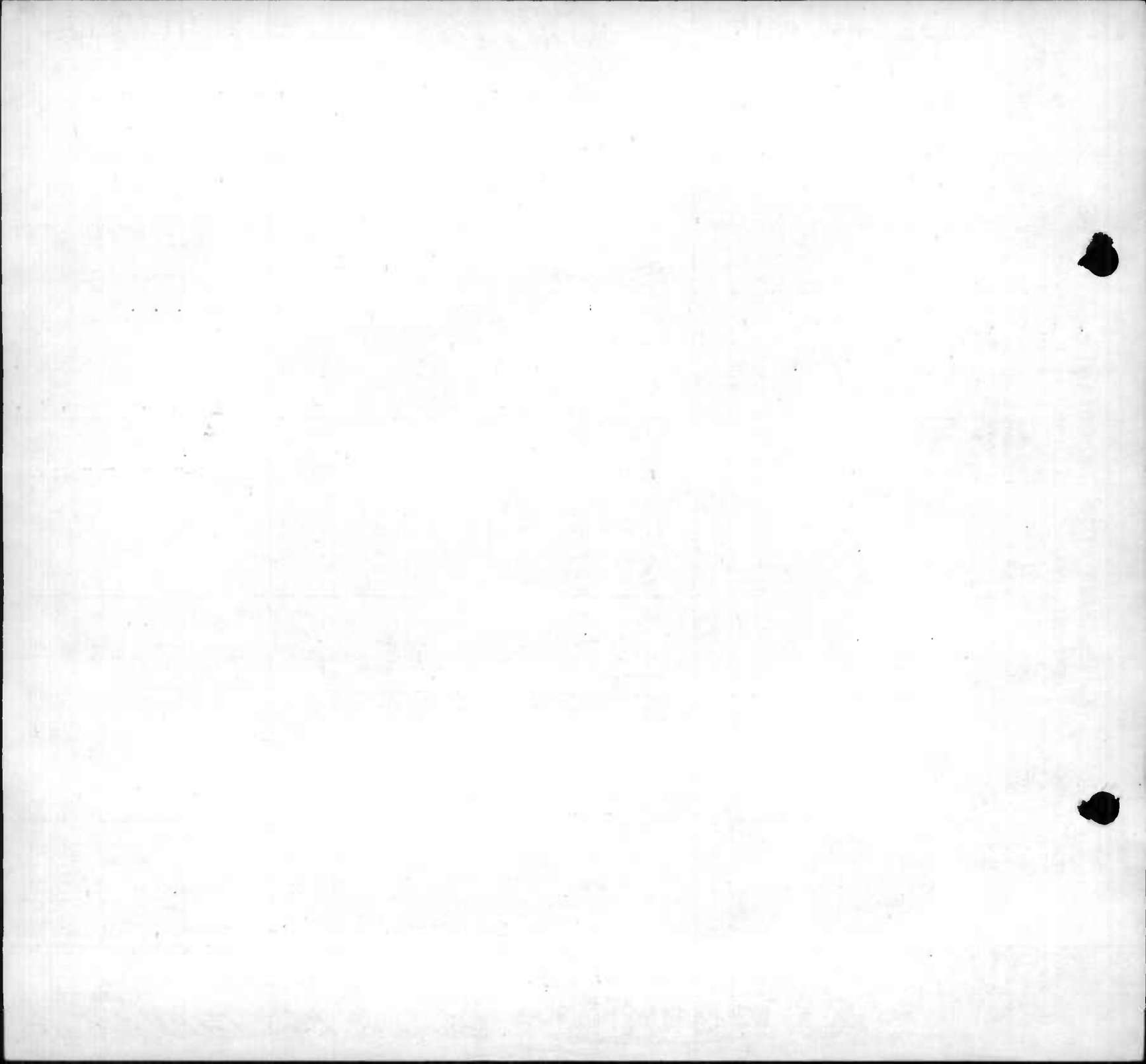
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0816	
CERTIFICATE OF DEATH					
BIRTH NO. 65 01789					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Baby Boy Johnson		2. DATE AND HOUR OF DEATH JAN 21-1965 3:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for the Women of Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Chase (20) Maryland			
		D. STREET ADDRESS (If rural, give location) P. O. Box 43			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1-21-65	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Michael Stewart Johnson			14. MOTHER'S MAIDEN NAME Margaret Cenn Hughes Box #43 Chase - Md.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mother's Chast.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 773.51		CAUSE OF DEATH (A) CARDIO-RESPIRATORY FAILURE (B) PREMATUREITY (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN. 21 1965 to JAN 21 1965, that (I) (we) lost saw the deceased alive on JAN 21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Estelita F. Gensoli M.D.				23B. DATE SIGNED JAN. 21, 1965	
23C. PHYSICIAN'S NAME (Type) ESTELITA F. GENSOLO, H.D.		23D. ADDRESS HOSPITAL FOR THE WOMEN OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/65		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens	
				24D. LOCATION (City, town, or county) (State) Belair, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR James Bruzdinski 1407 Eastern Ave. #21	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0815	
BIRTH NO. 65 0815		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ellen Ruth Wilson (William)		2. DATE AND HOUR OF DEATH January 22, 1965 4:10p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore 17, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 2219 Brunt Street					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH August 29, 1920	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Steve Norggins		14. MOTHER'S MAIDEN NAME Lizzie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 079-18-0210		17. INFORMANT Montell Wilson - 2219 Brunt St.-Balto, Md.	
18. 293X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Pulmonary Edema DUE TO (B) High Output Heart Failure DUE TO (C) Anemia		INTERVAL BETWEEN ONSET AND DEATH 1-12-65-1-22-65	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Systemic Lupus Erythematosus					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12-65 19 to 1-22-65 19, that (I) (we) last saw the deceased alive on 1-22-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hollis Seunarine, M.D.				23B. DATE SIGNED January 22, 1965	
23C. PHYSICIAN'S NAME (Type) Hollis Seunarine		23D. ADDRESS M.D. 1514 Division Street-Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George A. Allen 1348 N. Calhoun St.	



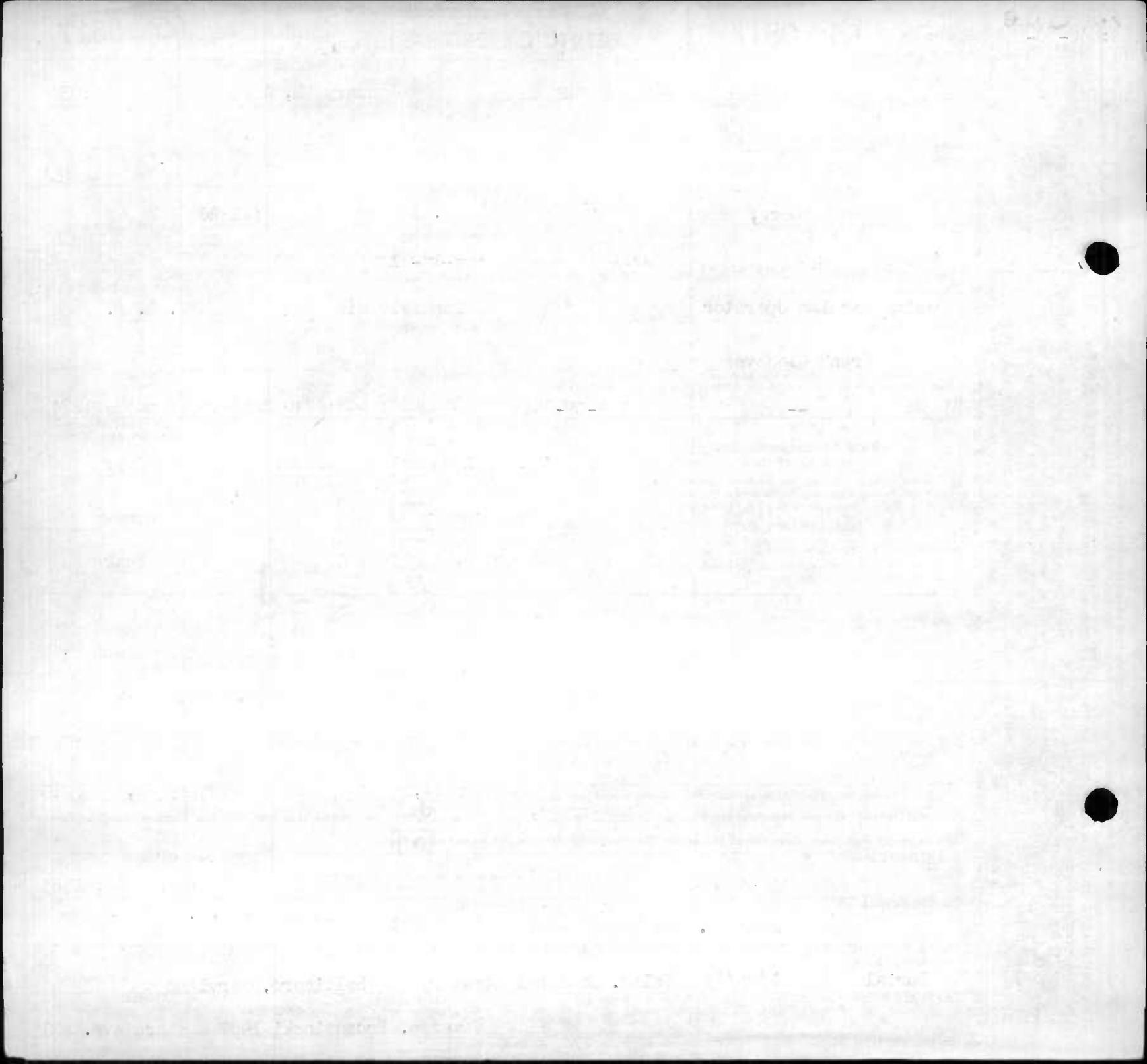
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 0817					Registered No. 65 0817				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) Violet Marie Moody					2. DATE AND HOUR OF DEATH January 22, 1965 12:05 a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL D. STREET ADDRESS (If rural, give location) Rt. 14 Box 621 #21220				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-14-11	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Operator			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Clodoveo					14. MOTHER'S MAIDEN NAME 7				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --			16. SOCIAL SECURITY NO. 174-09-8466		17. INFORMANT ADDRESS RECORDS: BCH:4940 Eastern Avenue #21224				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident DUE TO Probable Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 8 Days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension DUE TO Diabetes, Adult					Unknown 5 Years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 14, 1965 to January 22, 1965 , that (I) (we) last saw the deceased alive on January 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Howard K. Rathbun</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED January 22, 1965	
23C. PHYSICIAN'S NAME (Type) Howard K. Rathbun					23D. ADDRESS M.D. 4940 Eastern Avenue #21224				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/65		24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			25B. NAME OF REGISTRAR <i>Robert E. Farley</i>			25C. FUNERAL DIRECTOR <i>James E. Bruzdinski</i>			ADDRESS 1407 Eastern Ave. #21



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

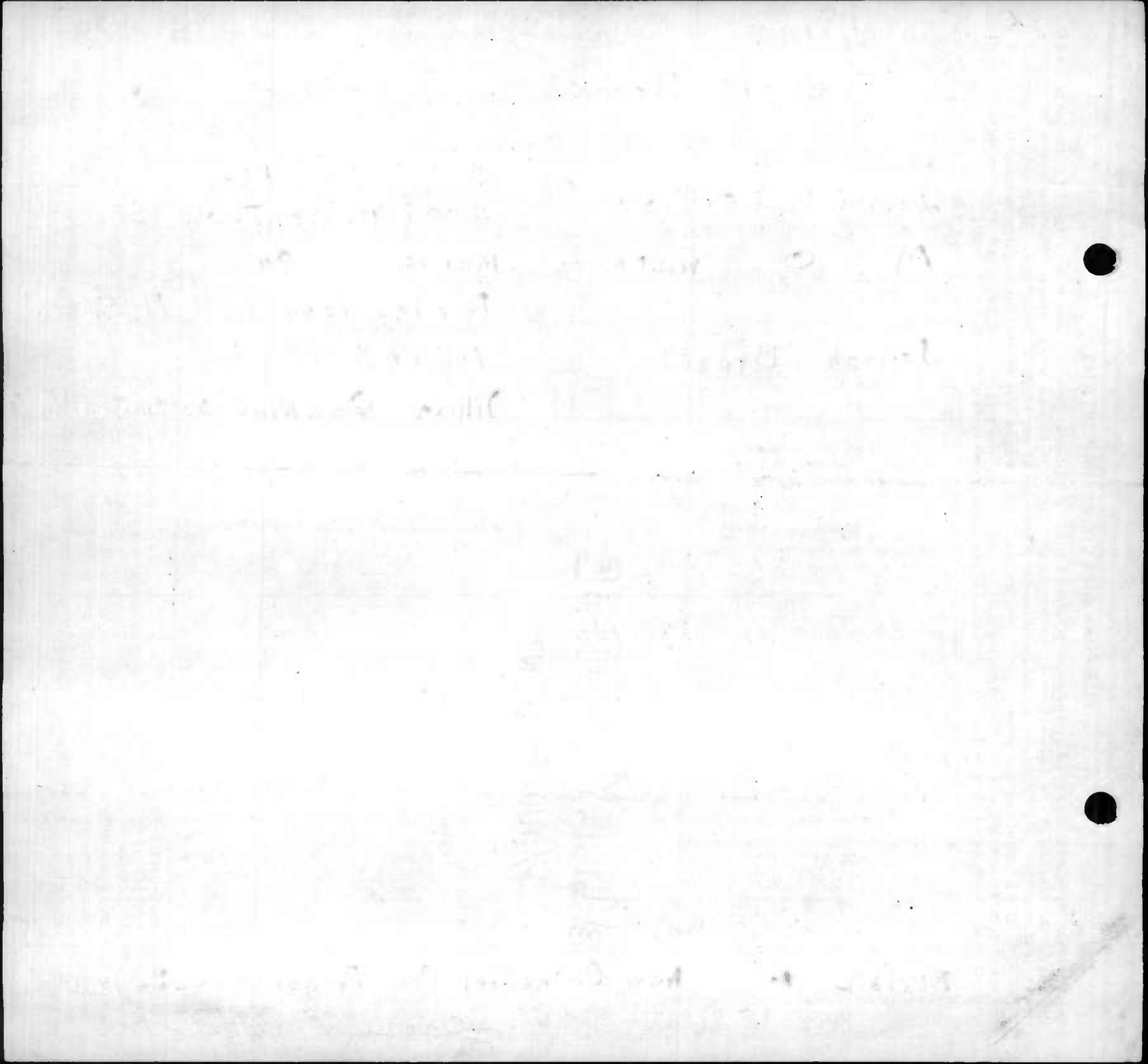
B. 6501		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0818	
BIRTH NO. 65 0818		CERTIFICATE OF DEATH		X	
M.E. CASE NO. 65 0818		1. NAME OF DECEASED (Type or Print) MARGARET A BROWN		2. DATE AND HOUR OF DEATH 1/21/65 1:53A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 22 C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 9 LARKWAY YORKWAY			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10B. KIND OF BUSINESS OR INDUSTRY U.S. Navy		8. DATE OF BIRTH 5/28/1908	
13. FATHER'S NAME Robert Tate		14. MOTHER'S MAIDEN NAME Eunice ?		9. AGE (In years last birthday) 65-58	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 093263		17. INFORMANT Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MULTIFORM		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
22. I certify that (I) (this hospital) attended the deceased from July 27 1964 to Jan 21 1965, that (I) (we) last saw the deceased alive on Jan. 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruben C. Guerrero		23B. DATE SIGNED 1/21/65		23C. PHYSICIAN'S NAME (Type) RUBEN C. GUERRERO	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME of CEMETERY or CREMATORY Western Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk	

Family Bible Record and Husband's
Affidavit 5-11-1965 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

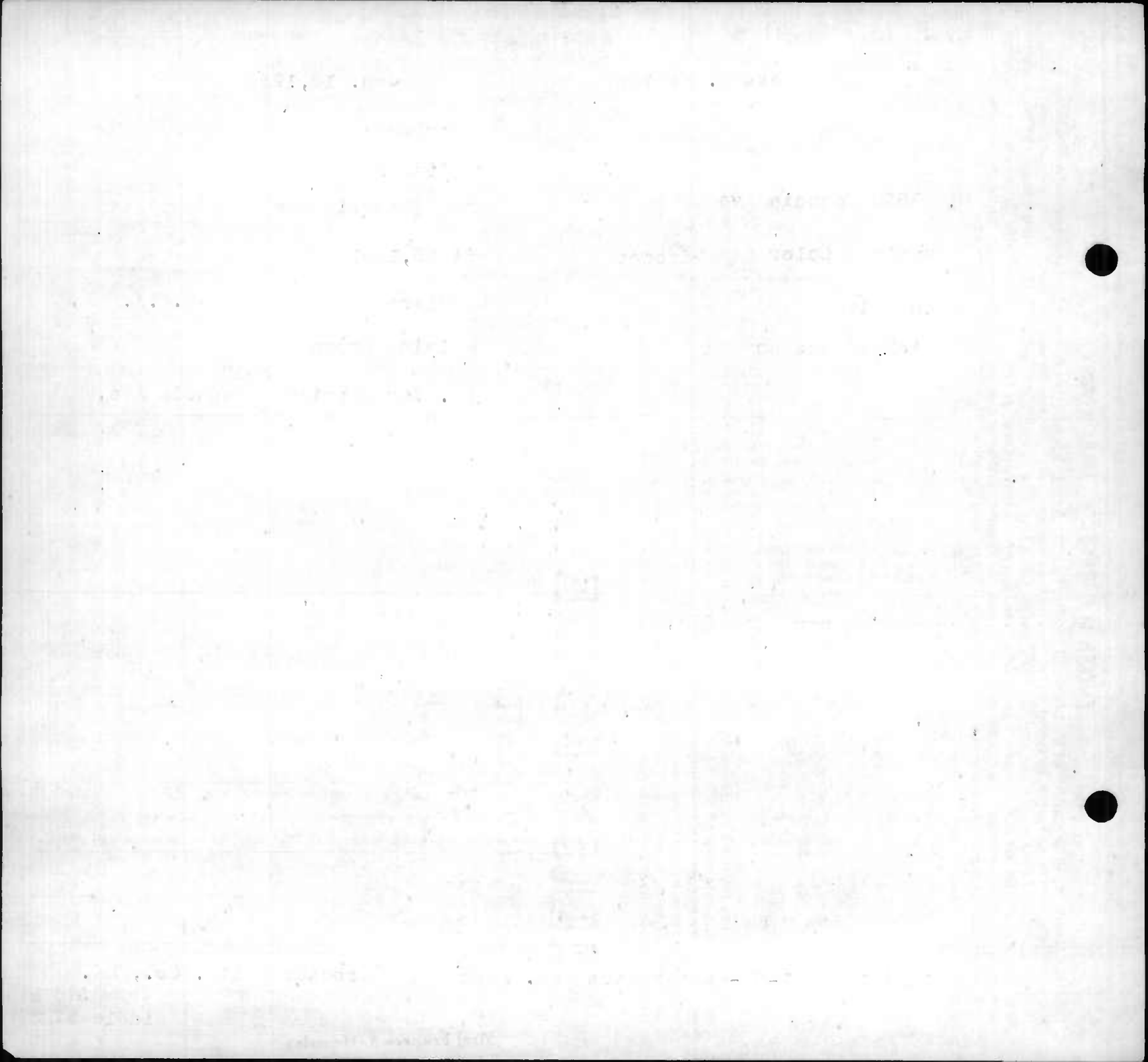
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0819</u>	
BIRTH NO. <u>65 0819</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>Francis Brooks</u>				2. DATE AND HOUR OF DEATH <u>1-21-65</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>2009 N. Bentlow St.</u>				A. STATE			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md.</u>			
				D. STREET ADDRESS (If rural, give location) <u>2009 N. Bentlow St.</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAY 12</u>	9. AGE (In years last birthday) <u>94</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tenley Town D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Brooks</u>				14. MOTHER'S MAIDEN NAME <u>AGNES</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Gaskins-2009 N. Bentlow St.</u>			
18. <u>43711</u> I				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <u>Cerebral Thrombosis</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <u>Myocardial Infarction</u>			
				(C) DUE TO <u>Congestive Heart Failure</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>Generalized Arteriosclerosis</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> 19 <u>63</u> to <u>1-21</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles R. Venter</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1-22-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles R. Venter</u>				23D. ADDRESS <u>2320 Eutaw Place Balto, 2127</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Calhadel Cent.</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd - Balto, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Tenley M.D.</u>		25C. FUNERAL DIRECTOR <u>Carrie F. Cooper - Prop.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

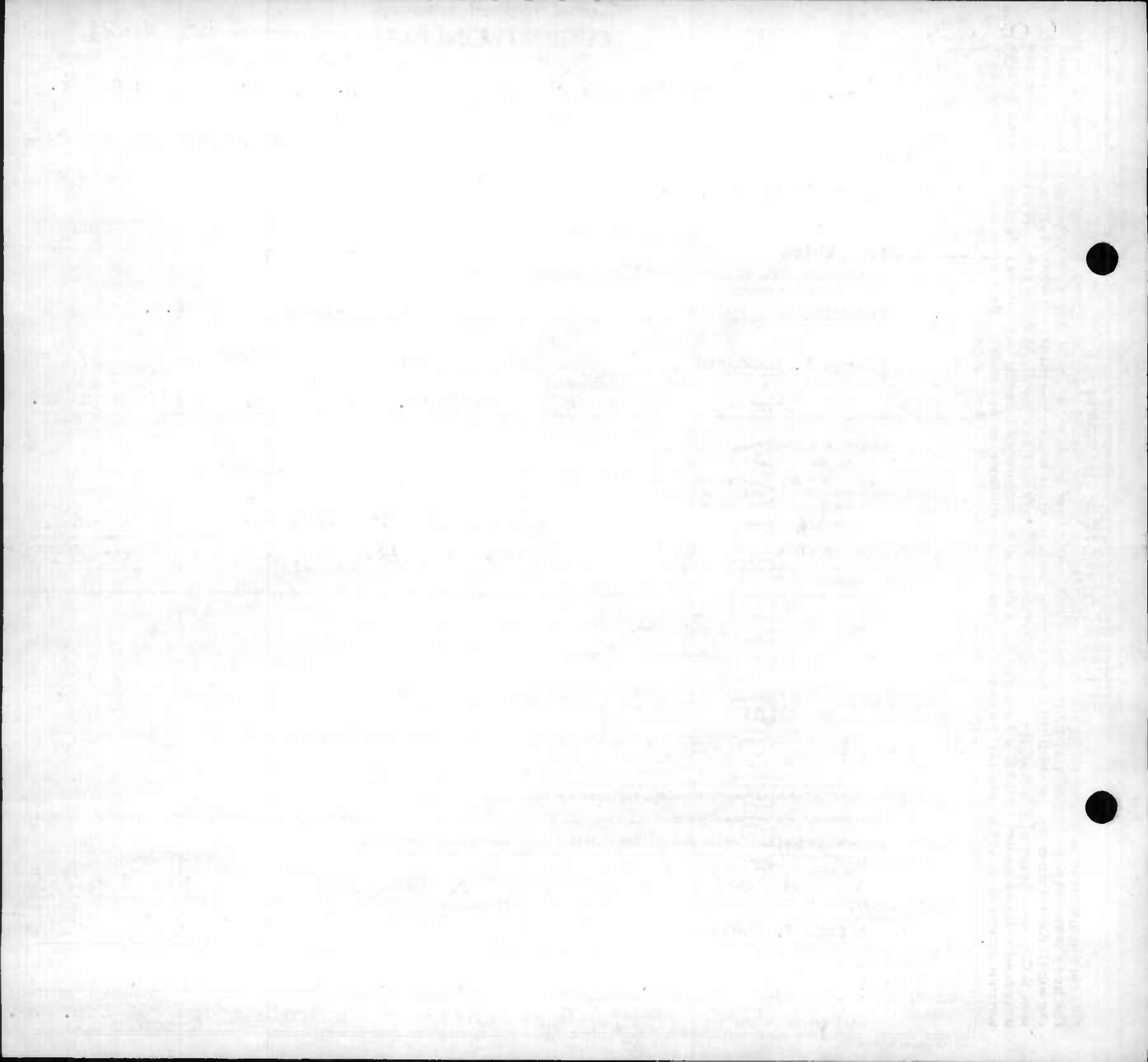
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0820		CERTIFICATE OF DEATH		65 0820	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rosa B. Hebron		Jan. 18, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3820 Sequoia Ave			A. STATE Maryland		
			B. COUNTY 15-10		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3820 Sequoia Ave		
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept 25, 1891	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard Boston		14. MOTHER'S MAIDEN NAME Melvina Brown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Vey Harried ADDRESS 3820 Sequoia Ave.	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Hypertensive Arteriosclerotic Heart Disease DUE TO (B) Diabetes Mellitus DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-7-1958 to 1-18-1965 , that (I) (we) last saw the deceased alive on 1-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Percival C. Smith				23B. DATE SIGNED 1-21-65	
23C. PHYSICIAN'S NAME (Type) Percival C. Smith				23D. ADDRESS 1709 Gwynns Falls Pkwy	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR (Mrs) Frances A. Hensley	
				ADDRESS 578 W Biddle St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

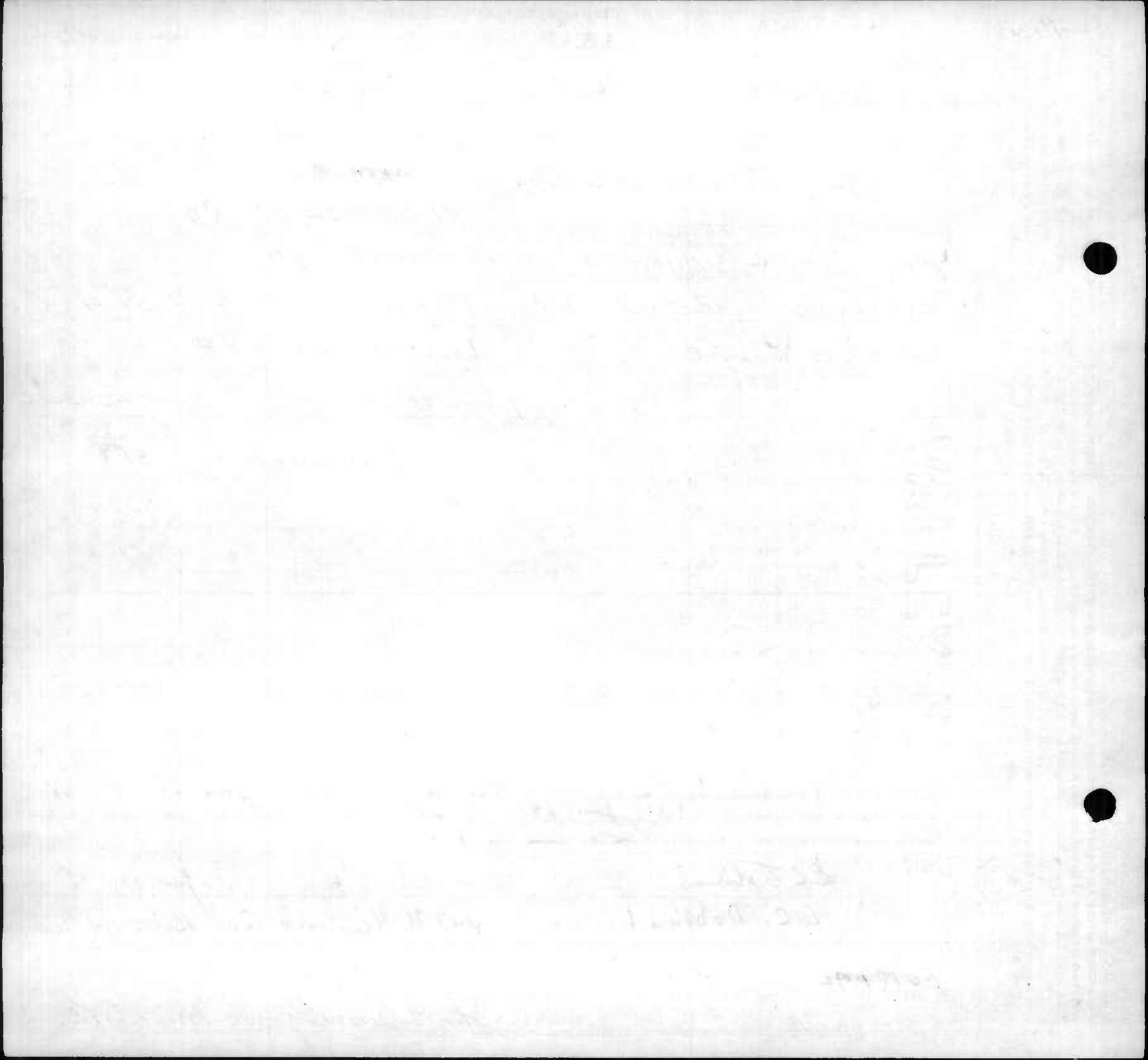
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0821	
BIRTH NO. 65 0821		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary Mrs. Lucy Woodward Vauthier		2. DATE AND HOUR OF DEATH Jan. 20, 1965 8:50 a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Frederick			
FULL NAME OF HOSPITAL OR INSTITUTION The Gundry Sanitarium, Inc		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 60-00			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location)			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/26/1877	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Connecticut	
13. FATHER'S NAME George P. Woodward		14. MOTHER'S MAIDEN NAME Mary Elizabeth Titus		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS David W. Vauthier 524 Nottingham Rd.	
18. 332X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES		(B) Cerebral Thrombosis		9 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Cerebral arterio sclerosis		10 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19..... to 19....., that (I) (we) last saw the deceased alive on 19..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. J. Shulman				23B. DATE SIGNED Jan. 20, 1965	
23C. PHYSICIAN'S NAME (Type) Alfred J. Shulman				23D. ADDRESS 1331 Reisterstown Rd. - Baltimore 21208	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/65		24C. NAME OF CEMETERY or CREMATORY St. Stephan's Ch. Cemt.	
24D. LOCATION (City, town, or county) (State) Millersville, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			
25B. NAME OF REGISTRAR Robert E. Fabry		25C. FUNERAL DIRECTOR ADDRESS Sterling Funeral Estate 736 Edm. Ave. Catonsville			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 0822</u>				
BIRTH NO. <u>65 0822</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>CLARENCE A. WOLFE</u>					2. DATE AND HOUR OF DEATH <u>JAN. 21-1965</u> <u>3¹⁰ A</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>7541 BERKSHIRE RD.</u>					A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO. 24 MD. 53-00</u>				
					D. STREET ADDRESS (If rural, give location) <u>7541 BERKSHIRE RD.</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-21-1885</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL CO.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>GEORGE WOLFE</u>					14. MOTHER'S MAIDEN NAME <u>LILLIAN SCHIPP</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-07-3607</u>		17. INFORMANT <u>GERTRUDE A.</u>		ADDRESS <u>SAME AS ABOVE</u>		
18. <u>442X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>cardio-renal-vascular disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1959</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				
					(B) DUE TO				
					(C) DUE TO				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>cardiac, senility,</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 21</u> 19 <u>64</u> to <u>Jan. 21</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.									
23A. SIGNATURE <u>L.C. Dobihal</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan. 22, 1965</u>		
23C. PHYSICIAN'S NAME (Type) <u>L.C. Dobihal</u>					23D. ADDRESS <u>447 N. Kenwood Ave. Balto. 24 Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-25-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>BELAIR MEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BELAIR. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>John S. Connolly</u>		ADDRESS <u>-300 Mace Ave.</u>			



LS: 42-67-14

CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0823

BIRTH NO. 65 0823

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John Seubreth

2. DATE AND HOUR OF DEATH

January 22, 1965 5:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

RURAL: 53-00

D. STREET ADDRESS (If rural, give location)

1906 Wareham Road #21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-16-28

9. AGE (In years
last birthday)

36

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Beth. Steel

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John F. Seuberth

14. MOTHER'S MAIDEN NAME

Mildred Downey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-20-5766

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ? Myocardial Infarct
DUE TO

3 Hours

(B) ? Central Nervous System Bleed
DUE TO

3 Hours

(C) ? Gastro Intestinal Bleed

3 Hours

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 22, 19 65 to January 22, 19 65, that (I) (we) last saw the deceased alive on January 22, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Howard K. Rathbun

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

January 22, 1965

23C. PHYSICIAN'S NAME (Type)

Howard K. Rathbun

M.D.

4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-25-65

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county) (State)

Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

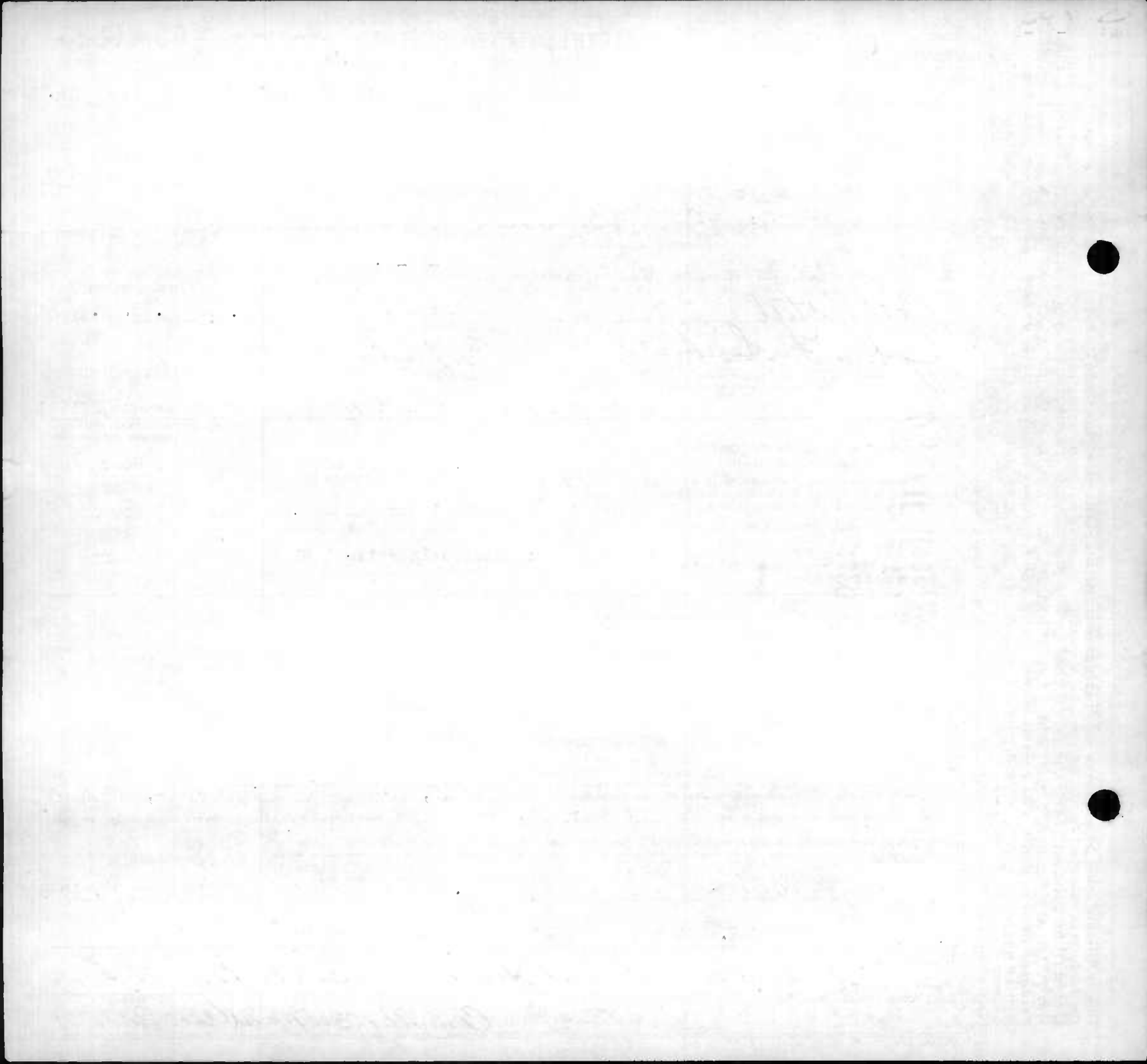
25C. FUNERAL DIRECTOR

Connolly 3300 Macaw Ave. Balto. 21

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

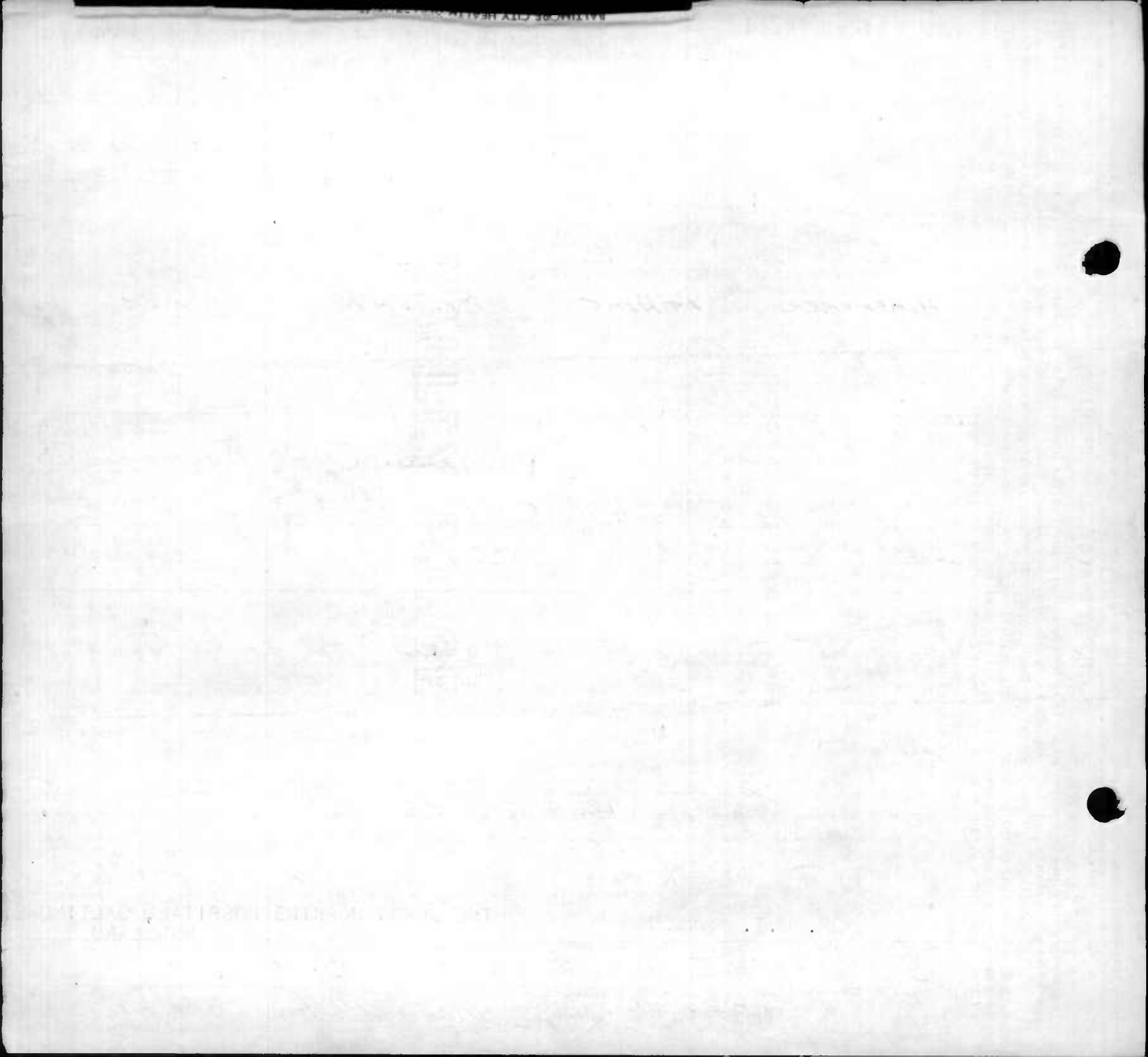
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

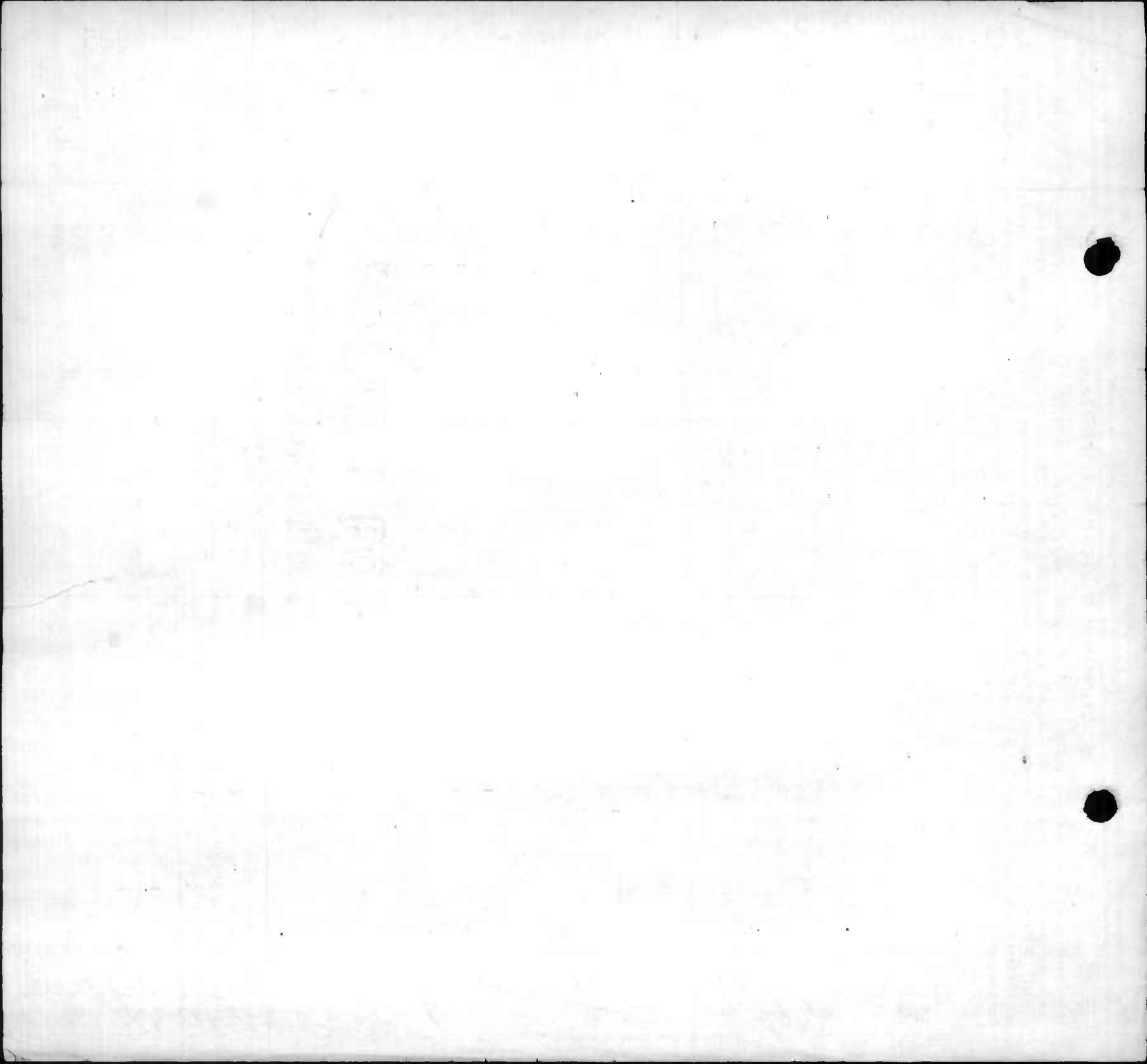
BIRTH NO. 65 0824				CERTIFICATE OF DEATH		Registered No. 65 0824	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) MARGARET CROSS				1-20-65 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND B. COUNTY 16-03			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 17				D. STREET ADDRESS (If rural, give location) 1611 HARLEM AVE.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-14-95	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL BEVANS				14. MOTHER'S MAIDEN NAME SARAH LEE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolization				CAUSE OF DEATH (A) DUE TO CHF		INTERVAL BETWEEN ONSET AND DEATH unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD				(B) DUE TO ASCVD		6 wks unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1.5 1965 to 1.20 1965, that (I) (we) lost saw the deceased alive on 1.20. 12:45 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE W.T. Maxson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1.20.65	
23C. PHYSICIAN'S NAME (Type) DR. W.T. MAXSON				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Marshall P. Payne		ADDRESS 638 N 616 MORRIS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

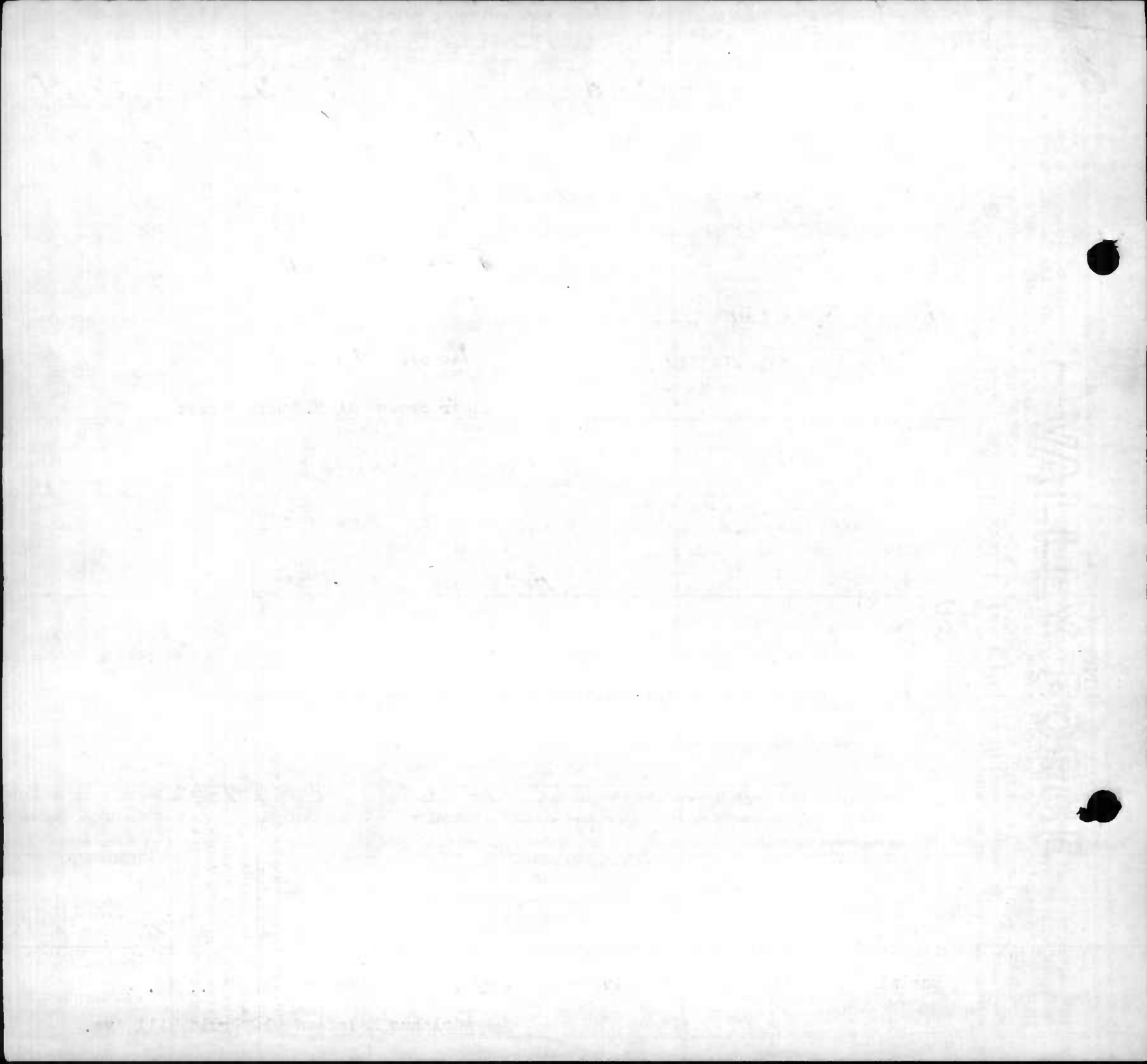
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0825	
BIRTH NO. 65 0825		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Myrtle West		1-20-65 2:55 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division St. Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 533 Robert St.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-27-1900	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Lancaster, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Mason		14. MOTHER'S MAIDEN NAME Louise Carter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 4-20-0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cerebral vascular accident (A) Pulmonary edema DUE TO (B) Arteriosclerotic heart disease DUE TO (C) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Peritoneal adhesions, massive Chronic hemorrhagic cystitis			
19A. DATE OF OPERATION 2-12-18-64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-15-64 19 to 1-20-65 19 that (I) (we) last saw the deceased alive on 1-20-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Arroyo				23B. DATE SIGNED 1-21-65	
23C. PHYSICIAN'S NAME (Type) J. Arroyo				23D. ADDRESS M.D. 1514 Division St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/65		24C. NAME of CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION A.A. Coerthuis		24E. NAME of REGISTRAR Robert E. Fisher, M.D.		24F. FUNERAL DIRECTOR J. Helstead	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 918 Duval St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 0826		65 0826	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				ANNIE HAMMOND		1-22-65 5:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
CHURCH HOME & HOSPITAL				Md. 18-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTO.			
				D. STREET ADDRESS (If rural, give location)			
				1007 W. FAYETTE ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F	NEGRO	WIDOWED	9-26-1903	61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSE KEEPER					BALTIMORE		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FRANK BROWN				ROSIE TROD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Edgar Brown 14 N. Mount Street	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) PULMONARY INFARCTION DUE TO			
				(B) CHRONIC CONGESTIVE DUE TO HEART FAILURE			
				(C) ARTERIO-SCLEROTIC HEART DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-19 1965 to 1-22 1965, that (I) (we) last saw the deceased alive on 1-22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Ephraim B. Barzaga						1-23-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
EPHRAIM B. BARZAGA				CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/27/65		Mt Calvary Cemetery		Ann Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 25 1965				Robert E. Farber		Adolphus Halstead 915 Druid Hill Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Smith 65 0827</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>65 0827</u>	
1. NAME OF DECEASED (Type or Print) <u>SMITH EDWARD</u>				2. DATE AND HOUR OF DEATH <u>1-21-65</u> <u>10:25 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL OF MD.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2500 ELSMORE AVENUE</u>			
5. SEX <u>M.</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARR.</u>	8. DATE OF BIRTH <u>2-29-12</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Archie M. Smith</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Ferguson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>UNK.</u>			17. INFORMANT <u>DELORES SMITH</u>		ADDRESS <u>2500 ELSMORE</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF THE LUNG</u> <u>W/ METASTASIS TO BRAIN</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> 19 <u>65</u> to <u>1-21</u> 19 <u>65</u> , that (I) <u>we</u> last saw the deceased alive on <u>1-21</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jesus G. Santiano</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-22-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>JESUS G. SANTIANO</u>				23D. ADDRESS <u>LUTHERAN HOSP. OF MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-24-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Jeffersonston Church Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Jeffersonston, Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>		25C. FUNERAL DIRECTOR <u>James Washington, D.C.</u>		ADDRESS <u>116 Mass. Ave. N.W.</u>	

W. H. RAYMOND
DIRECTOR OF THE

LS: 42-61-72

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0828

BIRTH NO.

65 0828

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)K.
Caroline Sunkel

2. DATE AND HOUR OF DEATH

January 21, 1965 10:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3125 Ravenwood Avenue #21213

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

5-2-97

9. AGE (In years
last birthday)
67If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Cross & Blackwell

11. BIRTHPLACE (State or foreign country)

Maryland, Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Adam Gossman

14. MOTHER'S MAIDEN NAME

Barbara Harold

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-22-9069

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18. 200.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Cerebral Vascular Accident
DUE TO

Metastasis Lympho Sarcoma

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Arteriosclerotic
Sepsis and Cardio-Vascular Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 15, 19 65 to January 21, 19 65,
that (I) (we) last saw the deceased alive on January 21, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.O.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

January 21, 1965

23C. PHYSICIAN'S
NAME (Type)

Howard K. Rathbun

23D. ADDRESS

M.D.

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/25/65

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

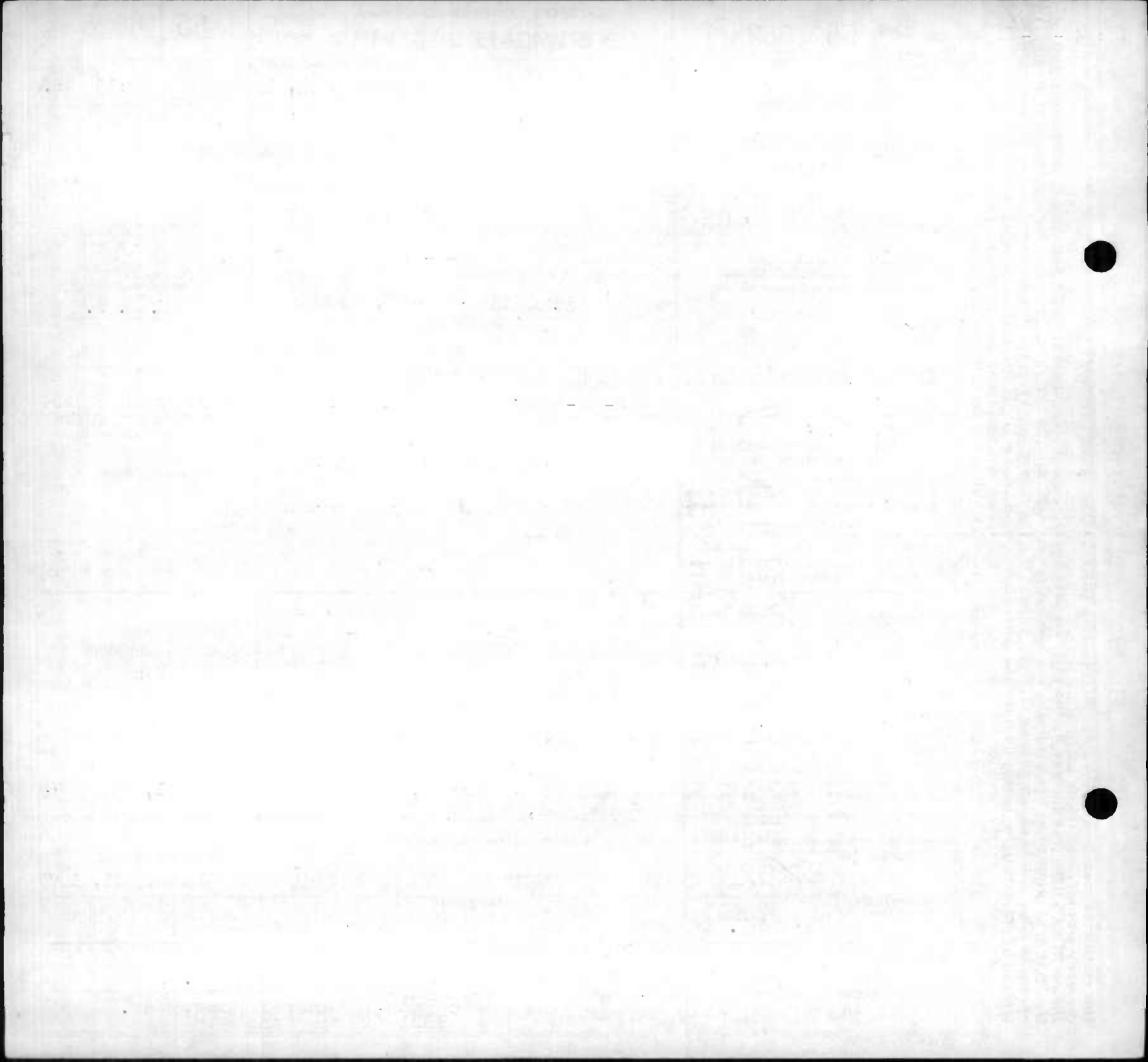
25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

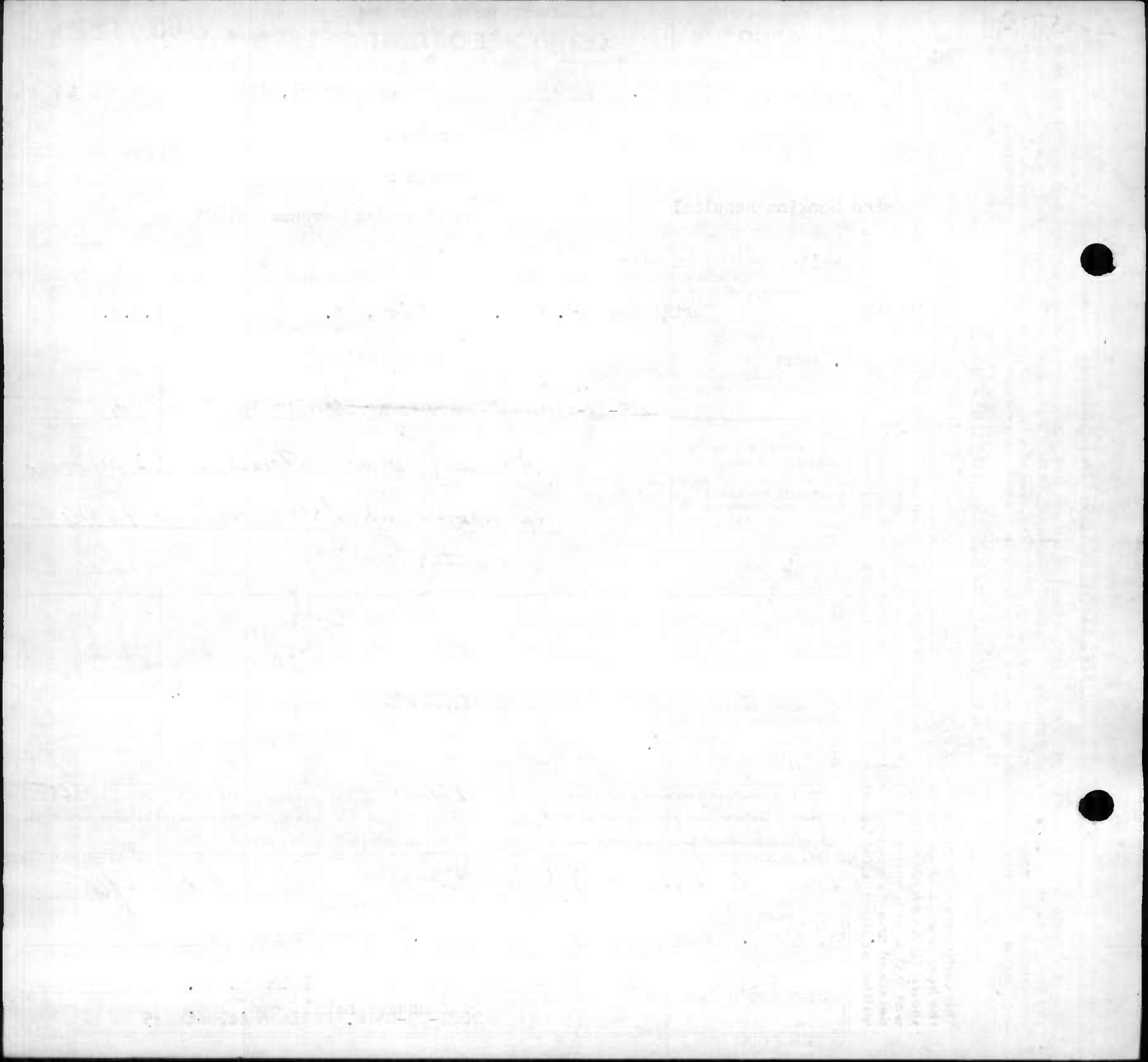
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0829</u>	
BIRTH NO. <u>65 0829</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN HERBERT LAMM SR.			2. DATE AND HOUR OF DEATH January 21, 1965 <u>6 am</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2630 Ashland Avenue 21205		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/5/96	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10B. KIND OF BUSINESS OR INDUSTRY Curtis Bay Ord. Dept.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Charles F. Lamm			14. MOTHER'S MAIDEN NAME Mary Michaels		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-22-8340	17. INFORMANT ADDRESS Mary Lamm 2630 Ashland Avenue #5		
18. <u>420.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION IMMEDIATE			INTERVAL BETWEEN ONSET AND DEATH 2 YEARS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) GENERALIZED ARTERIOSCL.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 to <u>1-21-</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-20-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Benjamin B. Moses</i> M.D.			23B. DATE SIGNED <u>1/22/65</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Dr. Benjamin B. Moses			23D. ADDRESS M.D. 448 N. Luzerne Avenue #5		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR Schlimmer Funeral Home Inc			
25D. ADDRESS 2601-05-05 E. Madison Street #5					



SAB 42-57-48
R. 5381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0830

BIRTH NO. 65 0830

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Raymond Ringold Ringgold

2. DATE AND HOUR OF DEATH

1-21-1965 5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals,
4940 Eastern Avenue,
Baltimore, Maryland-21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

707 North Appleton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Widowed Married

8. DATE OF BIRTH

3-28-1881

9. AGE (In years last birthday)

83

If Under 1 Yr. Months Days If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Samuel Ringgold

14. MOTHER'S MAIDEN NAME

Sarah

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Hepatic Coma
DUE TO
Common Bile Duct Obstruction
INTERVAL BETWEEN ONSET AND DEATH
5 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) Stone-vs-Neoplasm
DUE TO
months-years
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Possible Gastro Intestinal Bleeding
Days

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work Not While At Work 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-11-1965 to 1-21-1965, that (I) (we) last saw the deceased alive on 1-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE 23B. DATE SIGNED 1-21-1965

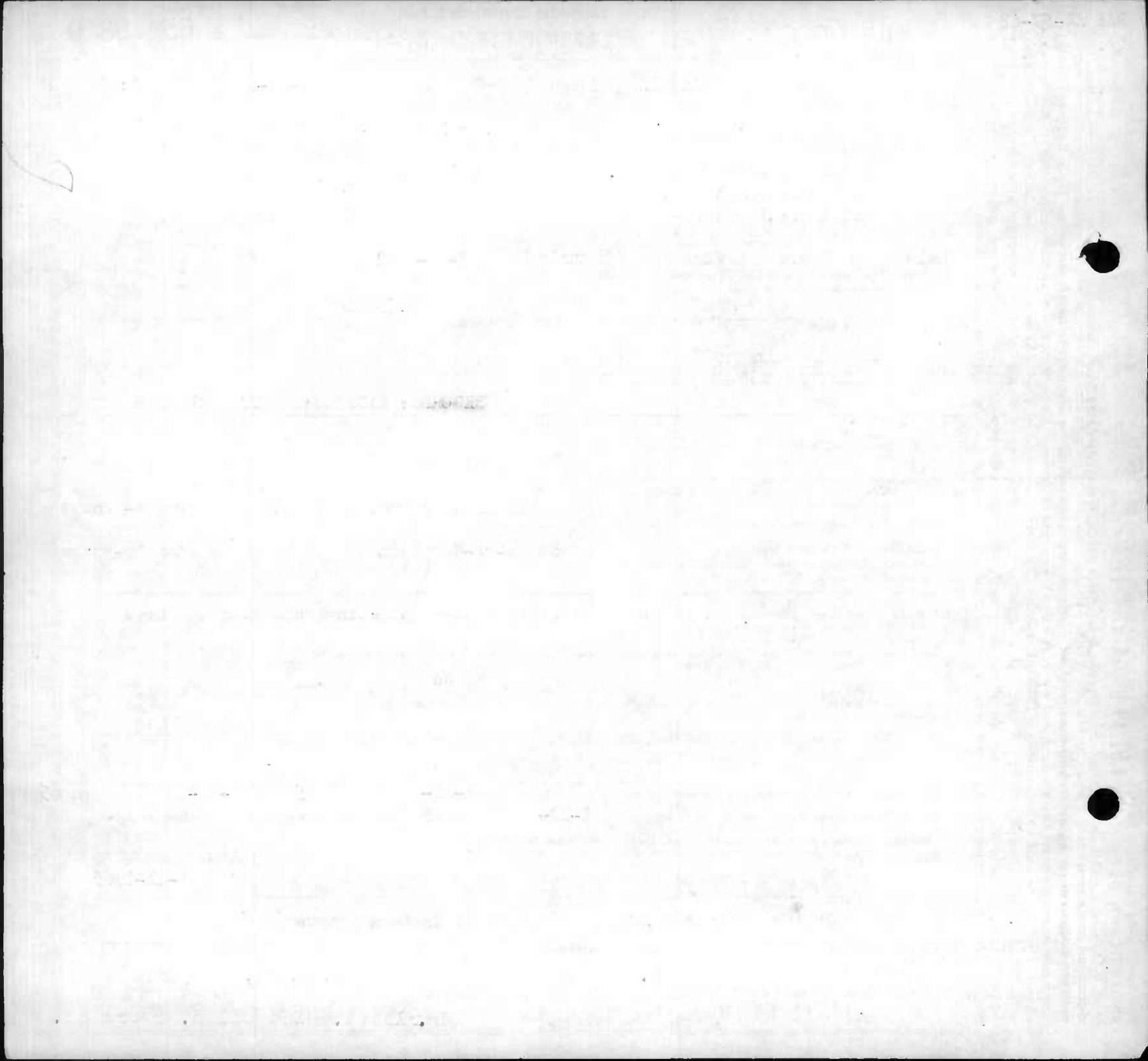
23C. PHYSICIAN'S NAME (Type) Julius Krevans, MD 23D. ADDRESS 4940 Eastern Avenue

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 1/26/65 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965 25B. NAME OF REGISTRAR Robert E. Fisher 25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.

FUNERAL DIRECTOR: IMPORTANT

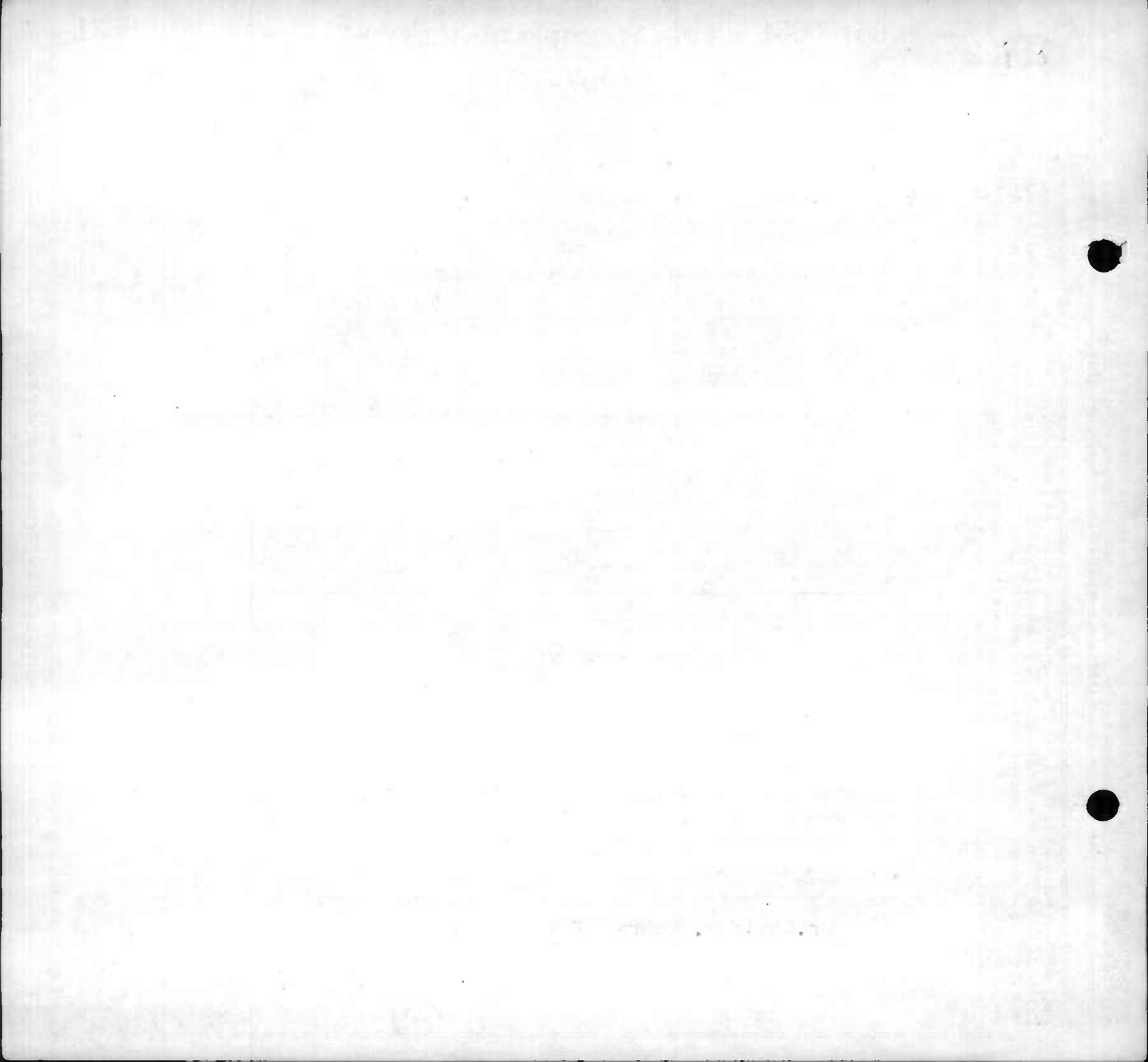
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0831	
BIRTH NO. 65 0831					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Boley, Hattie (HATTIE BOLEY)			2. DATE AND HOUR OF DEATH 1/20/65 2 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital Baltimore, Maryland			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 631 West Conway St.		
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1885	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Annie Harris 631 W. Conway St		
18. 692X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Severe dehydration DUE TO Chronic renal disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 PM 1/19/65 19 to 2 PM 1/20/65 19 that (I) (we) last saw the deceased alive on 1/20/65 at 2 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David W. Morse			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/20/65
23C. PHYSICIAN'S NAME (Type) Dr. David W. Morse			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/27/65	24C. NAME OF CEMETERY or CREMATORY Baltimore National City		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barrre St	



G. 4311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0832

BIRTH NO. 65 0832

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GOLDBERG, DR. SIGMOND

2. DATE AND HOUR OF DEATH

Jan 22, 1965 3:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

15-10

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21215

D. STREET ADDRESS (If rural, give location)

3806 Egerton Rd.

5. SEX

M

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

5-23-14

9. AGE (In years
last birthday)

50

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Physician

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel D. Goldberg

14. MOTHER'S MAIDEN NAME

Annie Kloppers

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Leon Goldberg - 723 Howard Rd. Balto. 8

18. 230X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Cardiovascular collapse
DUE TO

Hours

(B) Bleeding glomus tumor of the
DUE TO liver days

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (nully medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1965 to Jan 22, 1965.
that (I) (we) last saw the deceased alive on Jan 22, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jose S. Maisog

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

1- -65

23C. PHYSICIAN'S
NAME (Type)

JOSE S. MAISOG

23D. ADDRESS

M.D.

Olund Ave & Aristed

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-22-65

24C. NAME OF CEMETERY or CREMATORY

UNITED HEBREW
WASHINGTON, BAYD

24D. LOCATION

(City, town, or county)

BALTIMORE

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

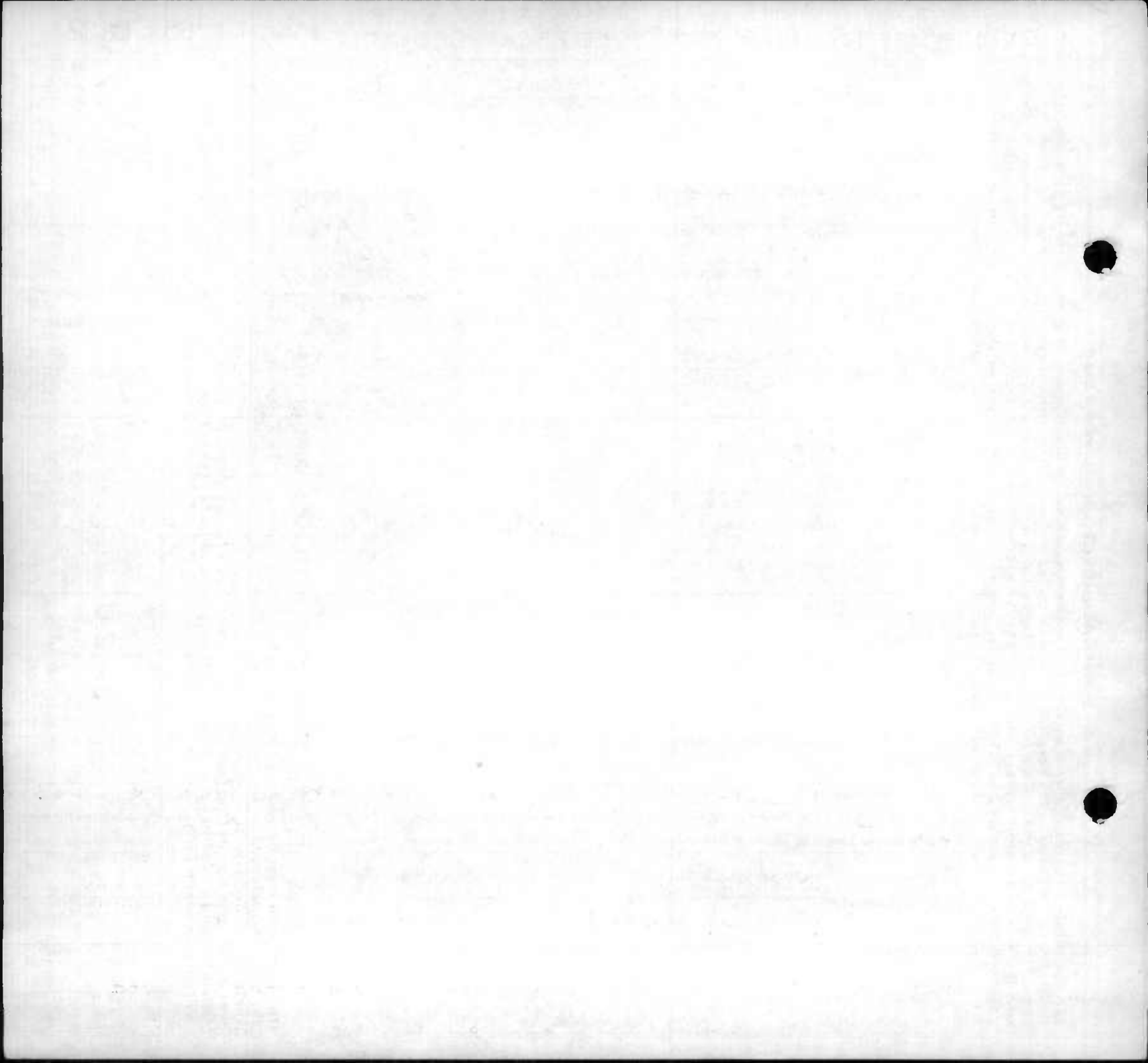
25C. FUNERAL DIRECTOR

ADDRESS

Jacob Shain's Inc., 2100 E. Main Pl

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0833BIRTH NO. 65 0833M.E. CASE NO. 593871. NAME OF DECEASED
(Type or Print)CHARLES W. SHIPLEY

2. DATE AND HOUR PRONOUNCED DEAD

January 23, 1965 4:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4257 Sheldon Avenue

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)Married

8. DATE OF BIRTH

March 23, 19079. AGE (In years
last birthday)57If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Martin Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.12. CITIZEN OF
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

George T. Shipley

14. MOTHER'S MAIDEN NAME

Margaret Thomas15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Frances C. Shipley-4257 Sheldon Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/6523A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

1-26-65

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

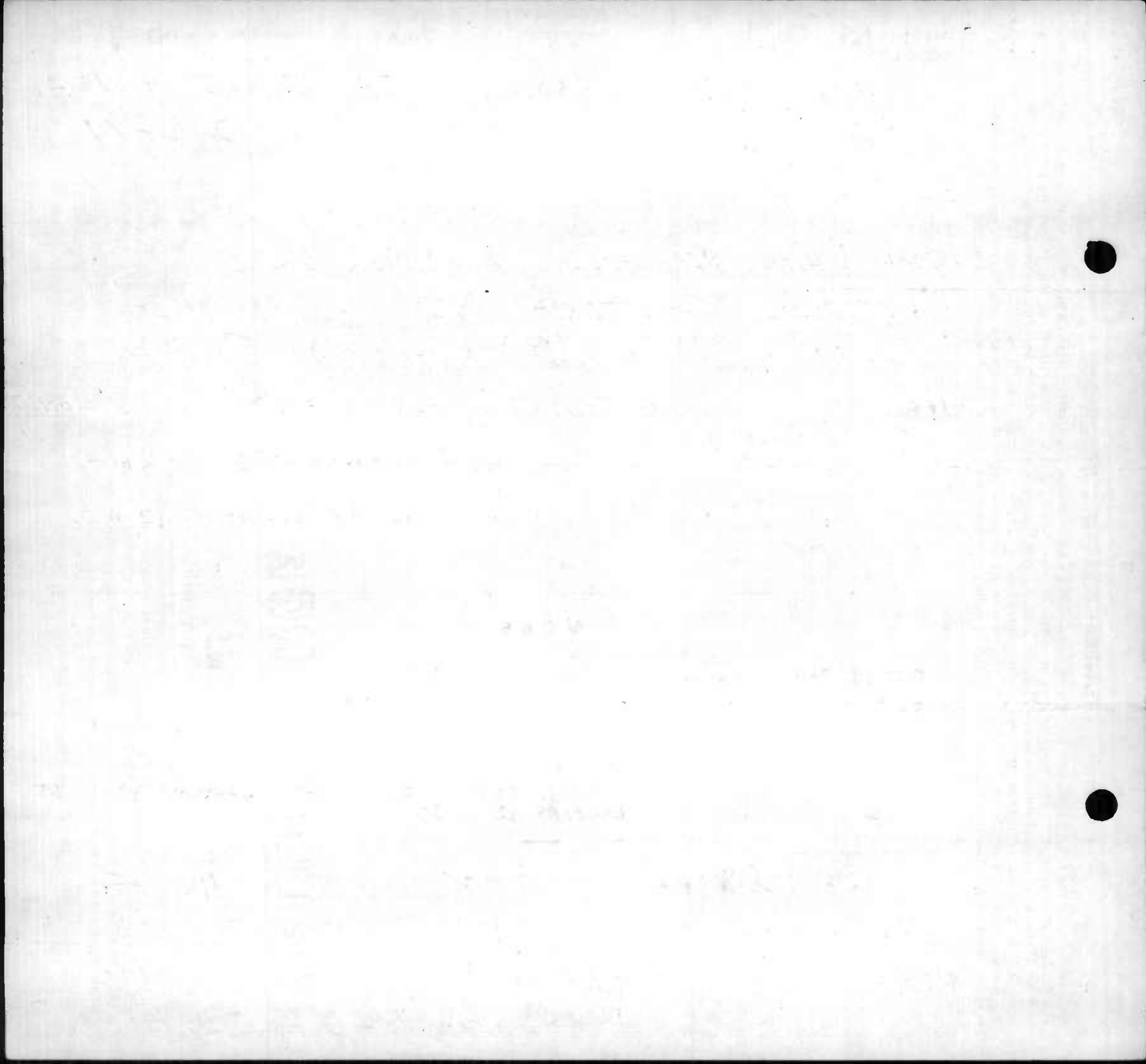
ADDRESS

John C. Miller Inc/6415 Belair Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

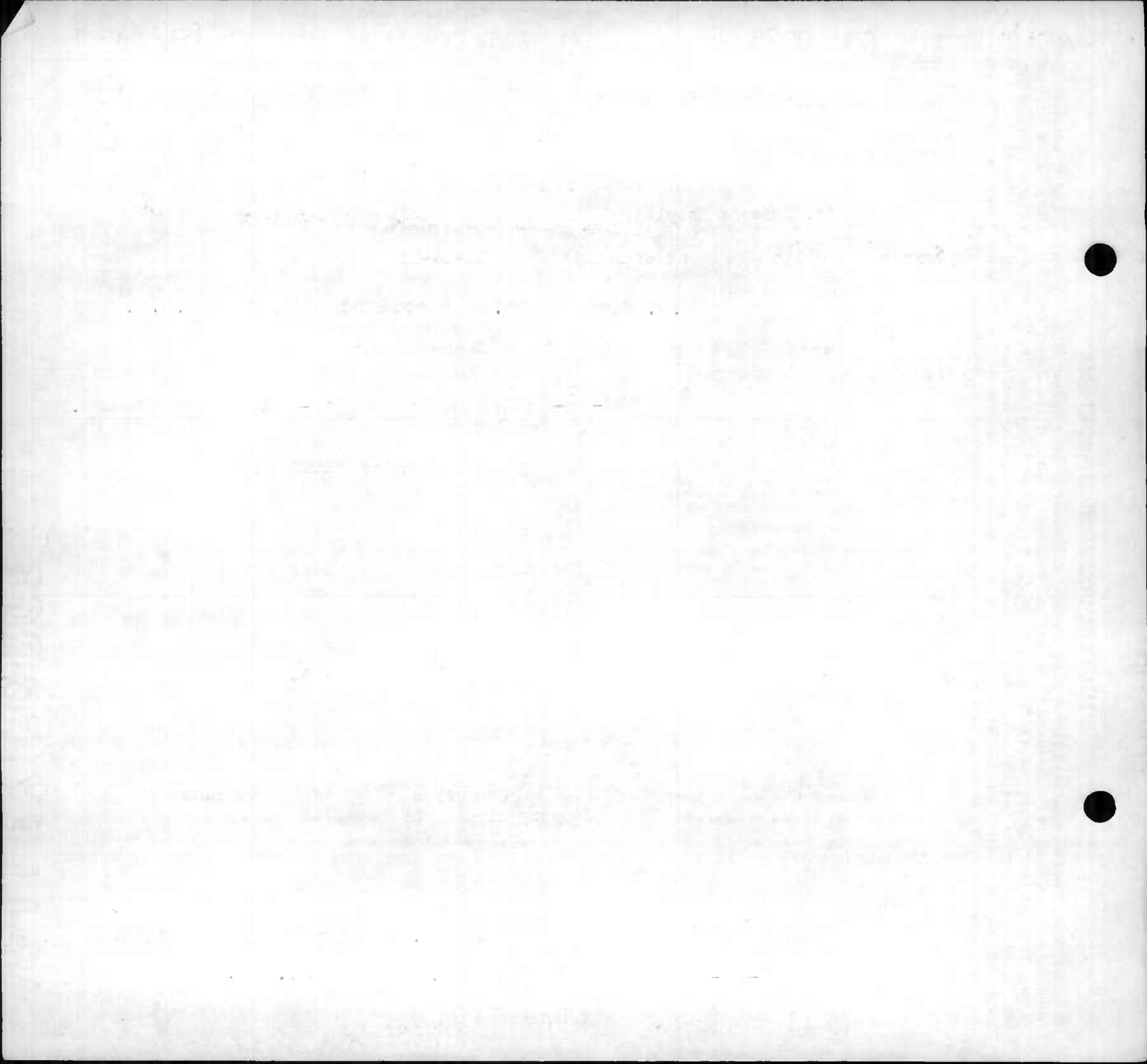
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0834				
BIRTH NO. 65 0834									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) HILDA SOPHIA HARMON					2. DATE AND HOUR OF DEATH JAN. 23, 1965 8:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3217 DILLON ST.					A. STATE MD.				
					B. COUNTY 26-11				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.				
					D. STREET ADDRESS (If rural, give location) 3217 DILLON ST.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED			8. DATE OF BIRTH AUG. 9, 1902	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS			10B. KIND OF BUSINESS OR INDUSTRY CAFETERIA		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CHARLES HARMON (DEC)					14. MOTHER'S MAIDEN NAME KATHERINE SMITH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 214-05-3927		17. INFORMANT ADDRESS CATHERINE SMITH 3217 DILLON ST		
18. 153331					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) CARCINOMATOSIS		INTERVAL BETWEEN ONSET AND DEATH 6 MO.		
					(B) CARCINOMA OF SIGMOID		12 MO.		
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE									
19A. DATE OF OPERATION OCT 19, 1964			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF SIGMOID		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from SEPT 30 1965 to JANUARY 23 1965 , that (I) was last saw the deceased alive on JANUARY 12 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.									
23A. SIGNATURE Paul G. Herold					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/23/65	
23C. PHYSICIAN'S NAME (Type) PAUL G. HEROLD					23D. ADDRESS M.D. 10 W. MADISON ST.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/26/65		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. CO. MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR ADDRESS George N. Hoffmann 3218 HUDSON ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

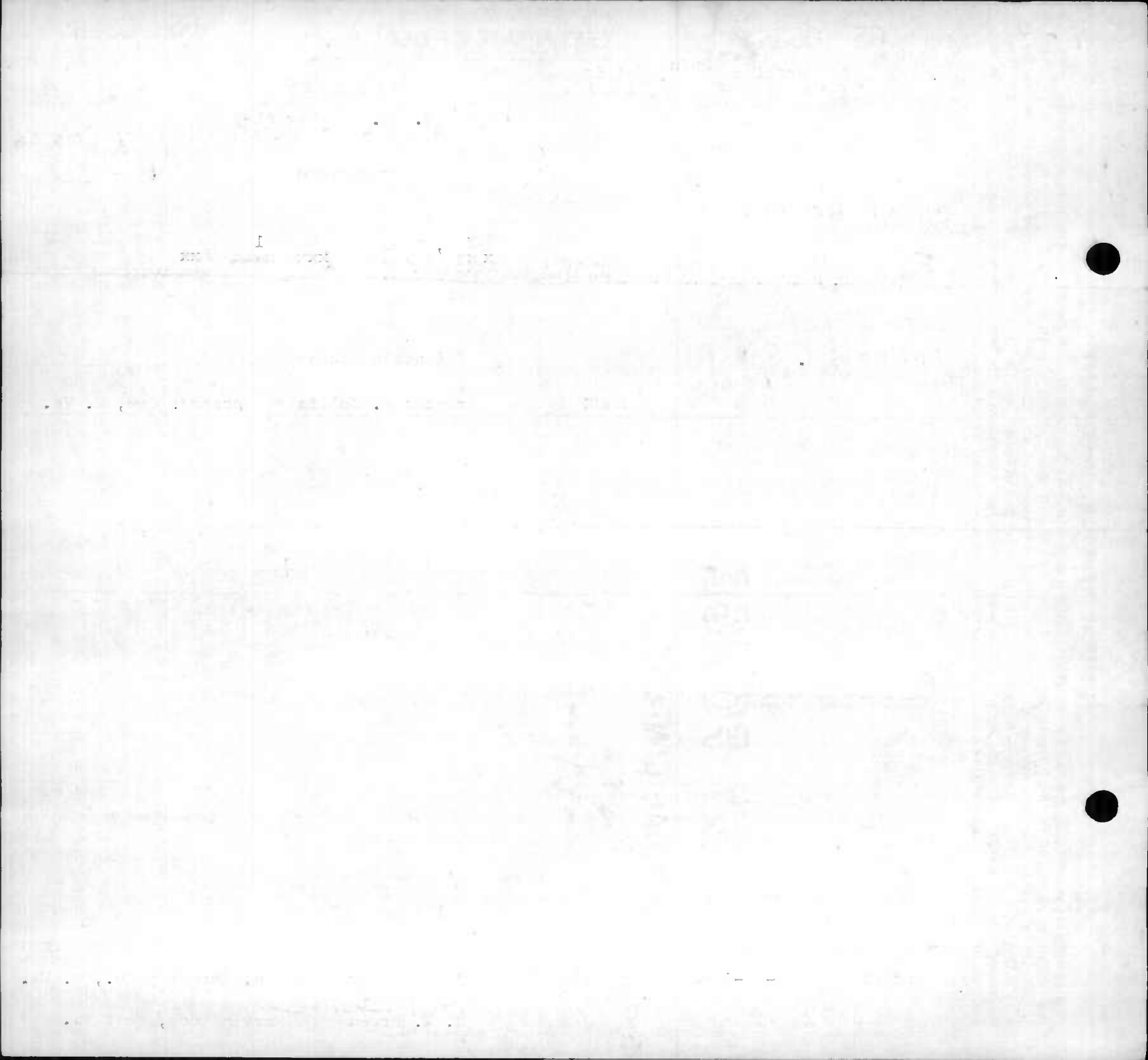
BIRTH NO. 65 0835				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0835	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Kramer, Mary Anna				January 21 1965 6P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
St. Josephs Hospital				Maryland 8-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore #13			
				D. STREET ADDRESS (If rural, give location)			
				1603 Normal Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
female	white	never married	11-10-82	82	Matron	Scotland	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Leonard Kramer				Anna Braun			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				212-22-8530		Leonard Kramer-6502 Rosemont Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Cerebro Vascular Thrombosis DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1 19 65 to January 21 19 65, that (I) (we) lost saw the deceased alive on January 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Salvador Marse						1/21/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Salvador Marse				M.D. 1400 N. Caroline St. #21213 Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-25-65		Holy Redeemer Cem.		Balto. Md.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 25 1965		Robert E. Fisher M.D.		John C. Miller Jr.		6415 Belair Rd. - #6	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 65 0836				Registered No. 65 0836	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) GERMAINE Dawn COLLIS			2. DATE AND HOUR OF DEATH 1/22/65 2:35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL			A. STATE W. VA. COUNTY Berkeley		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN GERRARDSTOWN, W. VA. (If outside city limits, write RURAL and give township) CODE 304		
			D. STREET ADDRESS (If rural, give location) Gerrardstown		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH May 4, 1963	9. AGE (In years last birthday) 1	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) W. VIRGINIA		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME FRANCIS M. COLLIS			14. MOTHER'S MAIDEN NAME Elizabeth Stewart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT Francis M. Collis			ADDRESS Gerrardstown, W. Va.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Tracheo. Esophageal Fistula since birth		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) Colon Transplant - 18 mos. Esophageal Dilatation		
19A. DATE OF OPERATION Age 18 mos.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED T.E. fistula		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/8 19 64 to 1/22 19 65 , that (I) (we) last saw the deceased alive on 1/22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE C. Phrellani		23B. DATE SIGNED Jan. 22/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-1965		24C. NAME of CEMETERY or CREMATORY Presbyterian Cemetery	
24D. LOCATION (City, town, or county) (State) Gerrardstown, Berkeley Co., W. Va.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.	
25C. FUNERAL DIRECTOR H. K. Brown		25D. ADDRESS Martinsburg, West Va.			



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65 0837

BALTIMORE CITY HEALTH DEPARTMENT

65 0837

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59359

1. NAME OF DECEASED
(Type or Print)

GEORGE HUWE

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1965 3:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

223 N. Patterson Park Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 20, 1914

9. AGE (In years last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

208-01-3825 Sophie Huwe 223 N. Patt. Pk. Ave.

17. INFORMANT

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-21-65

23C. NAME OF CEMETERY or CREMATORY

Oaklawn Cemetery

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

B. Dabrowski 2818 E. Baltimore St.

ADDRESS

10-10-17

10-10-17

Dec 10, 1917

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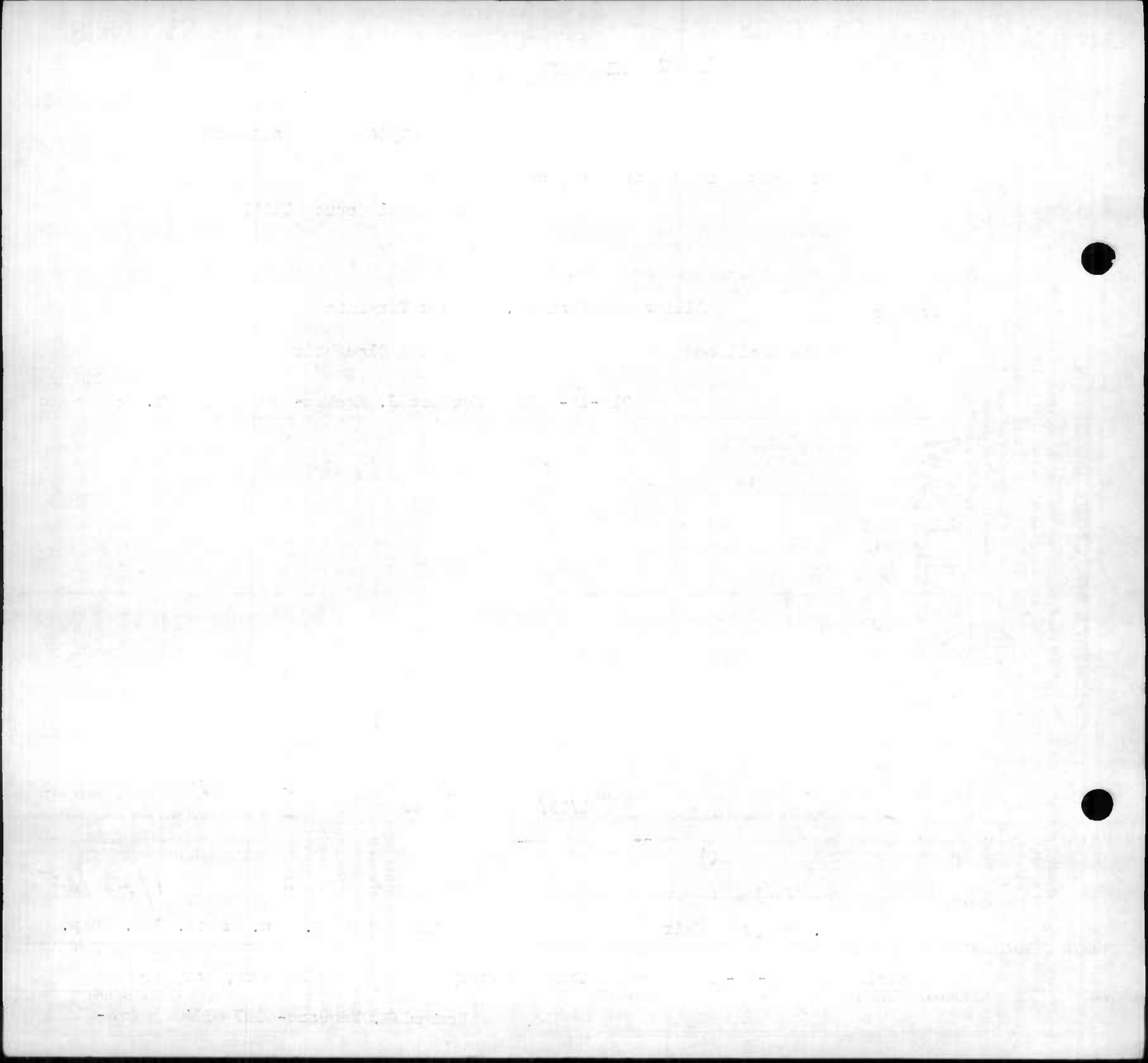
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0838		CERTIFICATE OF DEATH				Registered No. 65 0838			
M.E. CASE NO.		VIOLET ELIZABETH KECKEN				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Kecken Violet						1-23-65 1 6 55 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital						A. STATE B. COUNTY Maryland Baltimore			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lansdowne			
						D. STREET ADDRESS (If rural, give location) 800 Seckel Court 21227			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 9/23/23		9. AGE (In years lost birthday) 41		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY Allied Cehmical Co.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Louis Smallwood				14. MOTHER'S MAIDEN NAME Agnes Slaughter					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-18-6120		17. INFORMANT Norbert J. Kecken-800 Seckel Ct. Lansdowne			
18. 179-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Metastatic carcinoma - generalized. (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 1/9 19 65 to 1/23 19 65, that (we) lost saw the deceased alive on 1/23/ 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE W. Douglas Weir						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/23/65	
23C. PHYSICIAN'S NAME (Type) W. Douglas Weir				23D. ADDRESS M.D. 1213 Light St. So. Balto. Gen. Hosp.					
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave-21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0839	
BIRTH NO. 65 0839		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CAMPBELL, FRANCIS S.		2. DATE AND HOUR OF DEATH 1-21-65 2:50A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 2-1-65 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY A.A.			
5. SEX MALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED, DIVORCED, WIDOWED (specify) MARRIED	
8. DATE OF BIRTH 1-17-14		9. AGE (in years last birthday) 50-51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME WILLIAM			
14. MOTHER'S MAIDEN NAME LENA				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS ST. AGNES RECORDS--CATON & WILKENS AVE				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Liver Cirrhosis Esophageal varices ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from JANUARY 15 19 65 to JANUARY 21 19 65, that (I) (we) last saw the deceased alive on JANUARY 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Cecile G. Fisher M.D.				23B. DATE SIGNED 1-21-65		23C. PHYSICIAN'S NAME (Type) ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) AA Co. Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR McCully		25D. ADDRESS 237 Patapsco Ave. 25	

WATER FORCE

FUNERAL DIRECTOR: IMPORTANT

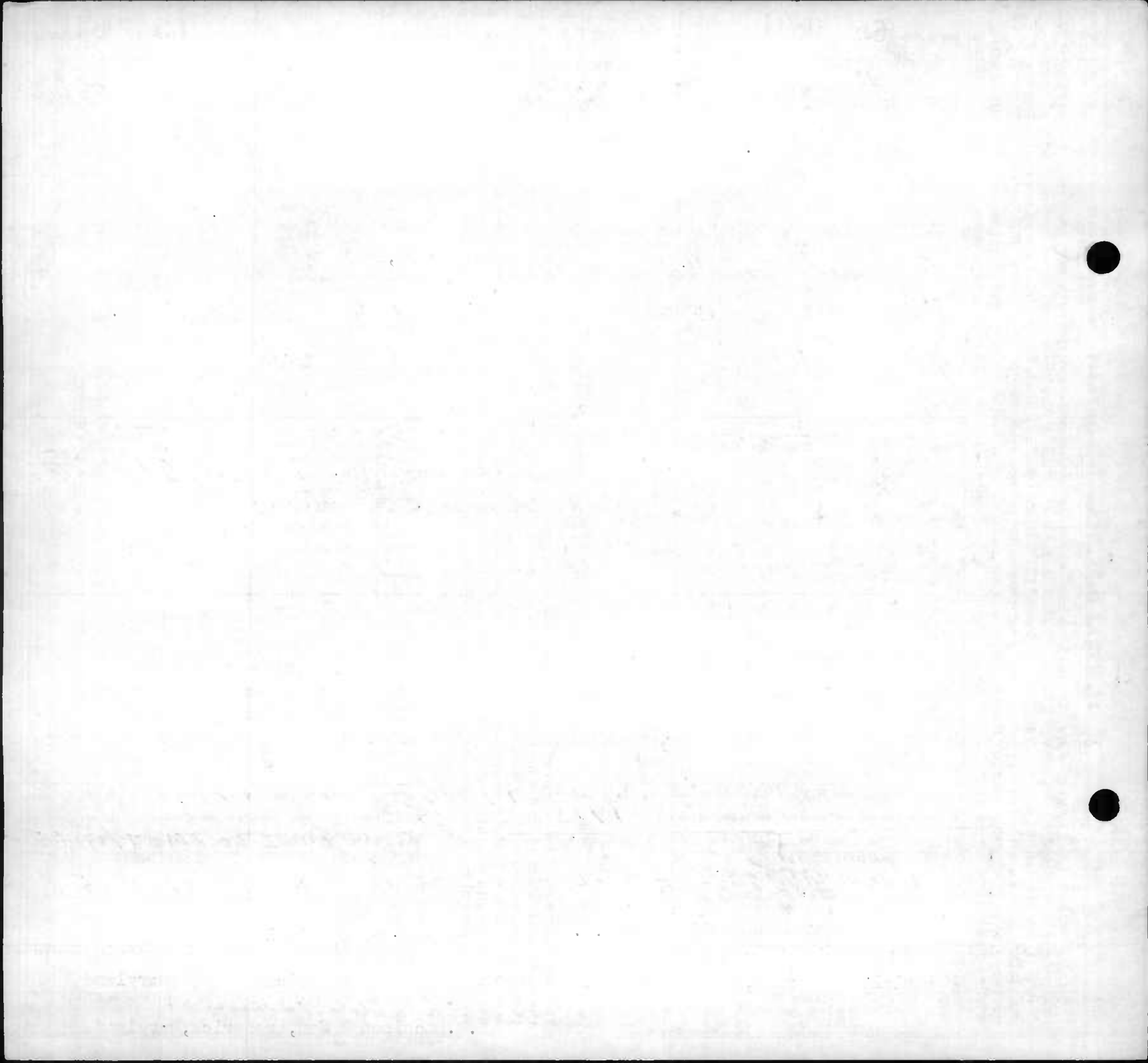
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0840	
BIRTH NO. 65 0840							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Sank, Jennie E.				2. DATE AND HOUR OF DEATH 430 pm Jan 24. 65 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland.		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY Anne Arundel Co.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Box 644 - Rt 2 52-00			
				D. STREET ADDRESS (If rural, give location) Sovereign park MD.			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W				14. MOTHER'S MAIDEN NAME Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. 5-22X I CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) pulmonary Edema			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) (Yes)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1 - 9 19 65 to 1 - 20 19 65 , that (I) (we) last saw the deceased alive on 1 - 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Leroy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) S. Leroy				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR McCully		ADDRESS 237 Patapsco Ave. 25	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0841					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 0841				
1. NAME OF DECEASED (Type or Print) <i>Howerton, Betty</i>					2. DATE AND HOUR OF DEATH <i>1-19-65 2:40 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Bon Secours Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>18-03</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>1012 Hollins Street</i>				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M.</i>	8. DATE OF BIRTH <i>October 25, 1929</i>	9. AGE (In years last birthday) <i>36</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Steel, Calvin</i>			14. MOTHER'S MAIDEN NAME <i>Virgil Smith</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Admission Sheet</i>			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>uremia due to carcinoma of uterus</i>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1/1/65</i> to <i>1/19/65</i> , that (I) (we) last saw the deceased alive on <i>1/18/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>on 2-00 AM 1/19/65</i>									
23A. SIGNATURE <i>MOHAMMAD TAGHI AMJAD</i> M.D.						23B. DATE SIGNED <i>1/19/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Mohammadtaghi Amjad M.D.</i>						23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 23, 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mount Olivet Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Frederick Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Donald F. Farley</i> <i>M.R. Etchison & Son, Frederick, Maryland</i>					



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO. 65 0842 64 31260

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
RICHARD TRAVERS		1/22/65 6:11 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hosp.		A. STATE Maryland	
		B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rosedale	
		D. STREET ADDRESS (If rural, give location) 500 Potomac Ave.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/9/64
9. AGE (In years last birthday) 3 1/2		10. BIRTHPLACE (State or foreign country) Md.	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Travers		14. MOTHER'S MAIDEN NAME Margaret Kridenoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Edward R. Travers 500 Potomac Avenue 6
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Waterhouse-Friedrichsen Syndrome (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner N. Spitz</i> EXAMINER'S NAME (Type) W.U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-26-1965	23C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cemetery
23D. LOCATION (City, town, or county) Baltimore		23E. DATE SIGNED 1/22/65	
24A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		24B. NAME OF REGISTRAR <i>Robert E. Farley</i>	24C. FUNERAL DIRECTOR <i>Lassahn Funeral Home 7401 Belair Road</i>
24D. ADDRESS Md.		24E. ADDRESS 36	

WALTER H. POLICE

WAVE CONTENT

Walter H. Police

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E 2601

65 0843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 0843

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LILLIAN EVANS EGER

2. DATE AND HOUR OF DEATH

JANUARY 20, 1965 1 630 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

UMON MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

M.D. BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

TIMONIUM 53-00

D. STREET ADDRESS (If rural, give location)

19 NORTHWOOD DRIVE

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10/21/09

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Self/Own Home

11. BIRTHPLACE (State or foreign country)

BALTIMORE, M.D.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT LOUIS EVANS

14. MOTHER'S MAIDEN NAME

MARTHA INEZ WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

N/A

16. SOCIAL
SECURITY NO.

N/A

17. INFORMANT

FRED O. SMITH, MD. Umon Memorial Hosp

ADDRESS

18. 195.7 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

METASTATIC PARAGANGLIOMA

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

13 mos.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

NONE

19A. DATE OF OPERATION

N/A

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

N/A

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

IV/A

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

N/A

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

N/A

21D. TIME
OF INJURY
(APPROX.)

N/A

21E. INJURY OCCURRED

N/A

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

N/A

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 20 1964 to JANUARY 20 1965,
that (I) (we) last saw the deceased alive on JANUARY 20 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Fred O. Smith

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

JANUARY 20, 1965

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 23, 1965

24C. NAME of CEMETERY or CREMATORY

Jessops Cemetery

24D. LOCATION

(City, town, or county)

(State)

Cockeysville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

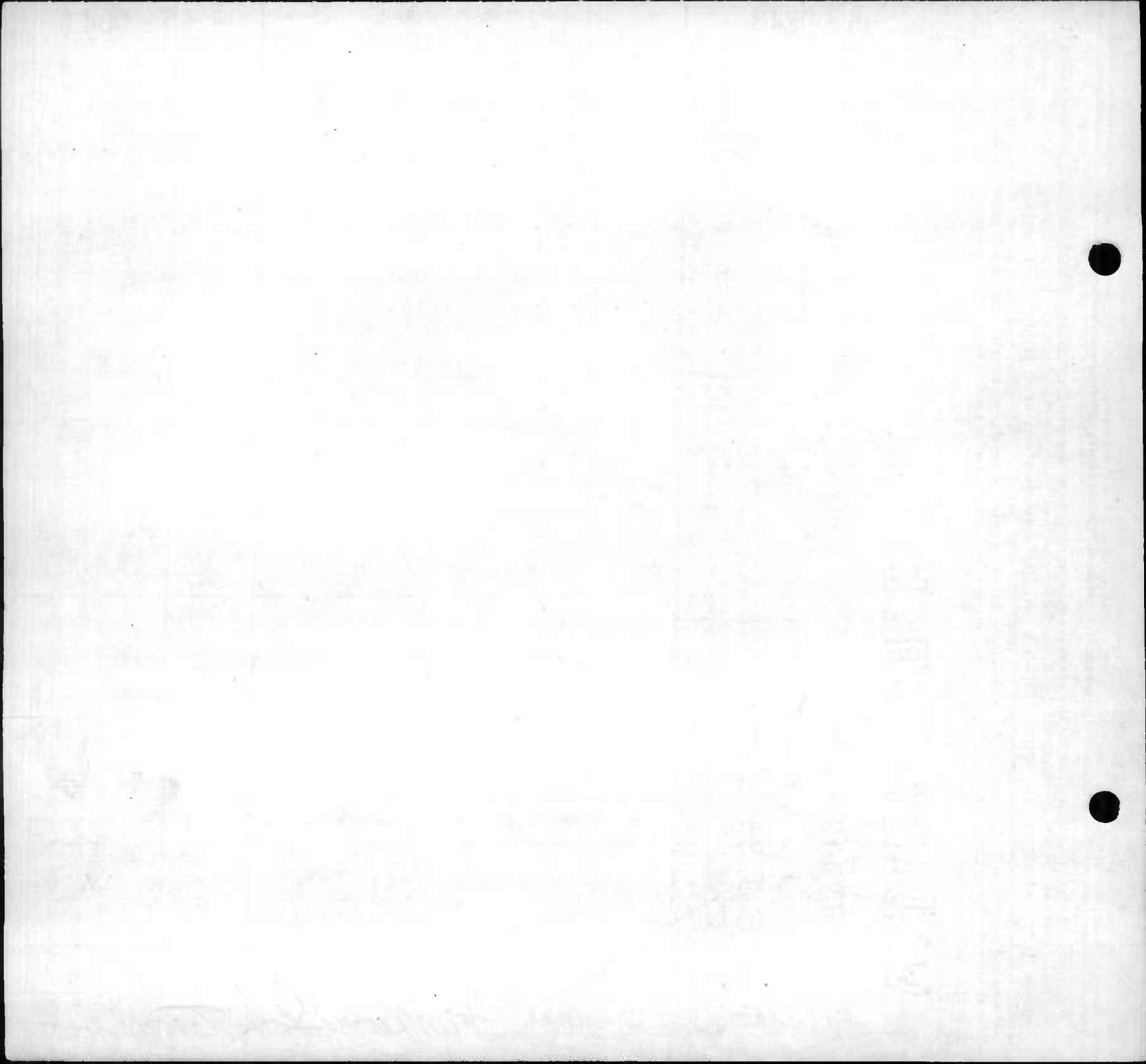
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

John Burns-Louis, Towson, Md.

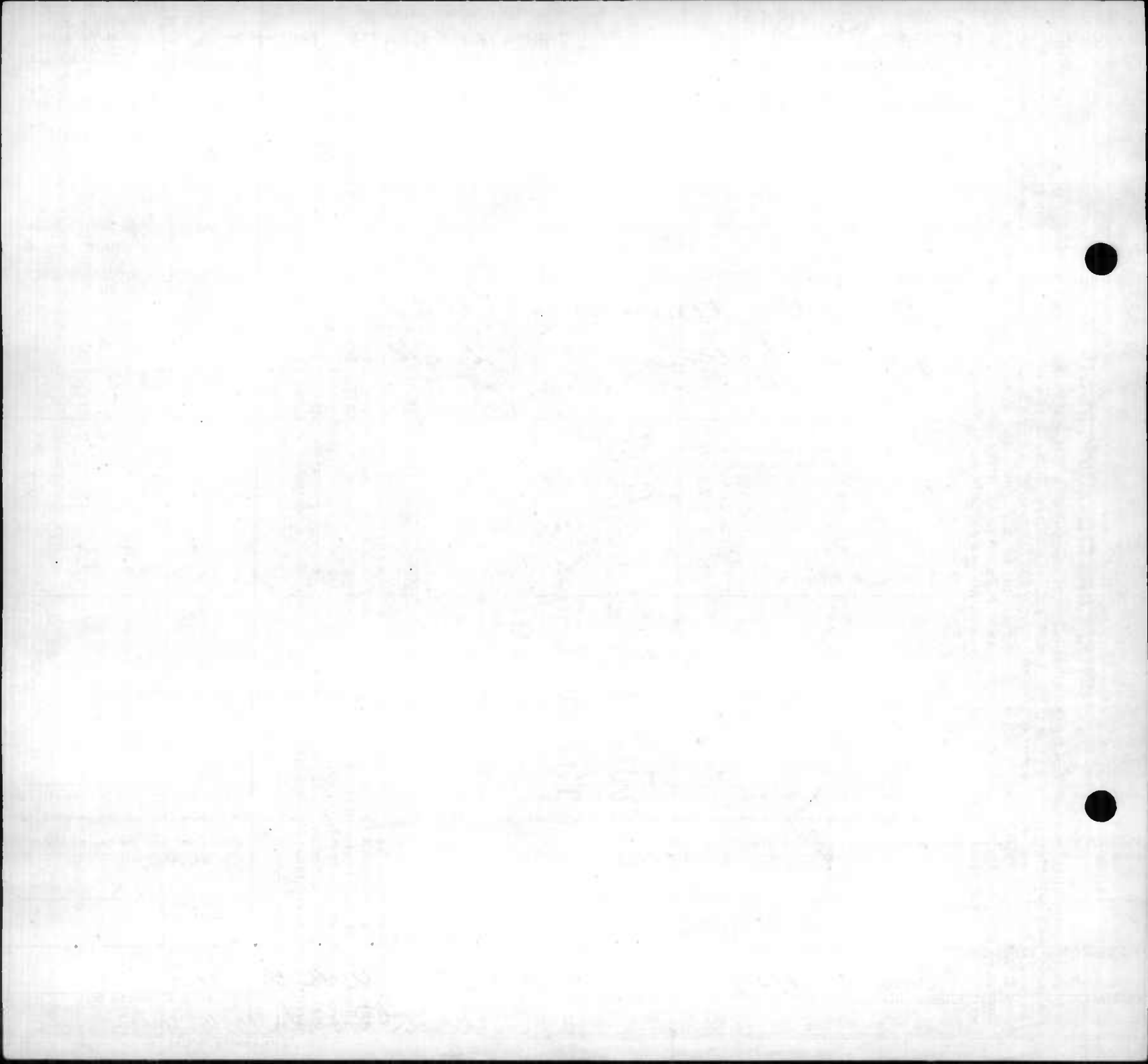
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

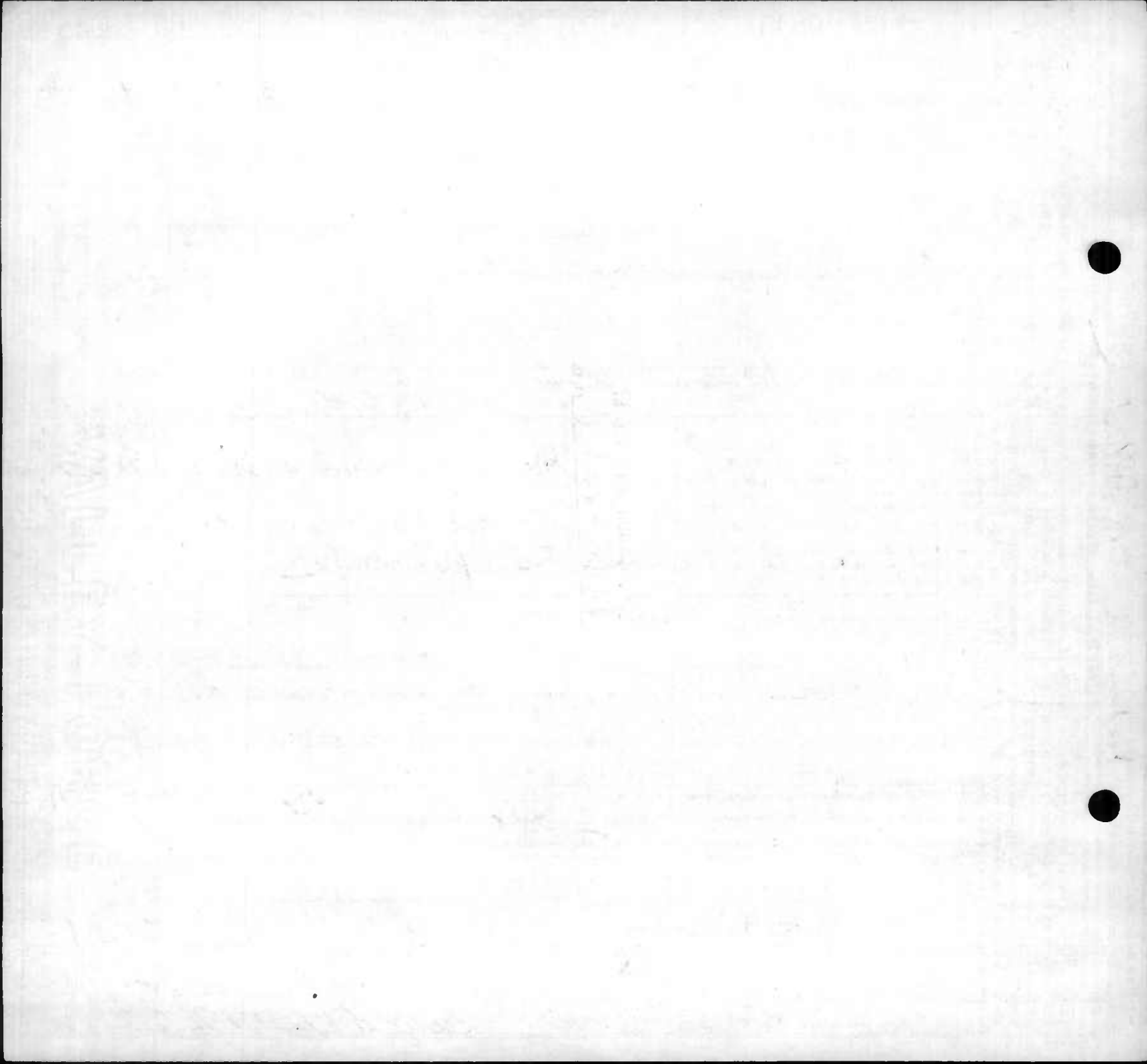
BIRTH NO. 65 0844		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0844	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) JOHN CHATMAN			1-18-65 19:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL			A. STATE MARYLAND B. COUNTY 2201		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 8 W. MONTGOMERY STREET		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1897	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Ala	
13. FATHER'S NAME John Chatman			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Opheelia Williams 111 W. Montgomery St	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Arteriosclerosis			
		(B) DUE TO Disease			
		(C) Drugs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from JANUARY 18, 1965 to JANUARY 18, 1965 , that X (we) last saw the deceased alive on JANUARY 18, 1965 and that in X (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Colin Heinritz				23B. DATE SIGNED 1/19/65	
23C. PHYSICIAN'S NAME (Type) COLIN HEINRITZ, M.D.				23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME of CEMETERY or CREMATORY Mt Calvary St	
24D. LOCATION (City, town, or county) (State) A A Co., Md		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.	
25C. FUNERAL DIRECTOR Robert L. Burman		25D. ADDRESS 108 W. Montgomery St			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released on Approval
FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0845	
BIRTH NO. 65 0845				M.E. CASE NO. 59389A	
1. NAME OF DECEASED (Type or Print) George H. Gittings				2. DATE AND HOUR OF DEATH Jan. 23, 1965 7:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 634 W. LaFayette Ave				A. STATE Maryland B. COUNTY 14-02	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 634 W. LaFayette Ave	
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 2, 1903	9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Alberta Gittings 634 W. LaFayette Ave			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Atherosclerotic Cardiovascular Disease myocardial Infarction Cor pulmonale		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 65 to 19 1962 that (I) (we) last saw the deceased alive on 12/19/62 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Garfield Kingston				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-26-65	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965				25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR George A. Kulan				25D. ADDRESS 1348 N. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0846

BIRTH NO. 65 0846
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) William C Davis

2. DATE AND HOUR OF DEATH
January 24, 1965 9 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

27 06

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

#14

D. STREET ADDRESS (If rural, give location)

5505 MORELLO Rd

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10-29-10

9. AGE (In years
last birthday)

54

10. Under 1 Yr. Months: Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

Gas & Electric Co.

11. BIRTHPLACE (State or foreign country)

BALTO., MD.

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

HARRY DAVIS

14. MOTHER'S MAIDEN NAME

CARRIE WILSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT
Mrs. Elda C. Hartley

ADDRESS

SAME

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

Pericarditis

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-24-65 to 1-24-65 19 65 that (I) (we) last saw the deceased alive on 1-24-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Francis X. Carmody

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-24-65

23C. PHYSICIAN'S NAME (Type)

FRANCIS X. CARMODY

M.D.

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/28/65

24C. NAME of CEMETERY or CREMATORY

DULANEY VALLEY MEMORIAL

24D. LOCATION (City, town, or county) (State)

BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

LEONARD J. RUCK, INC. BALTO., MD.

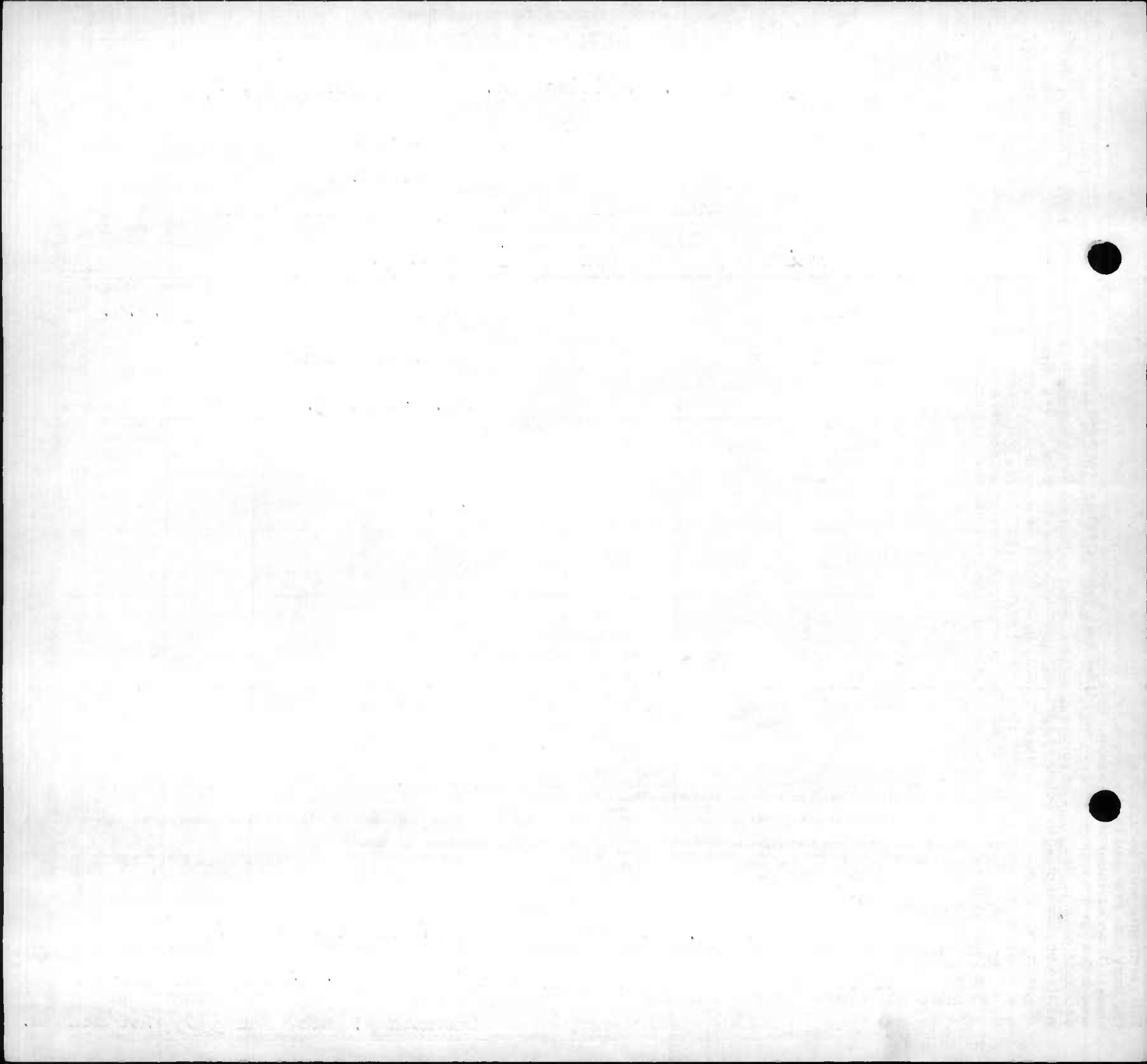
ADDRESS

10 1740 .X 2 0 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

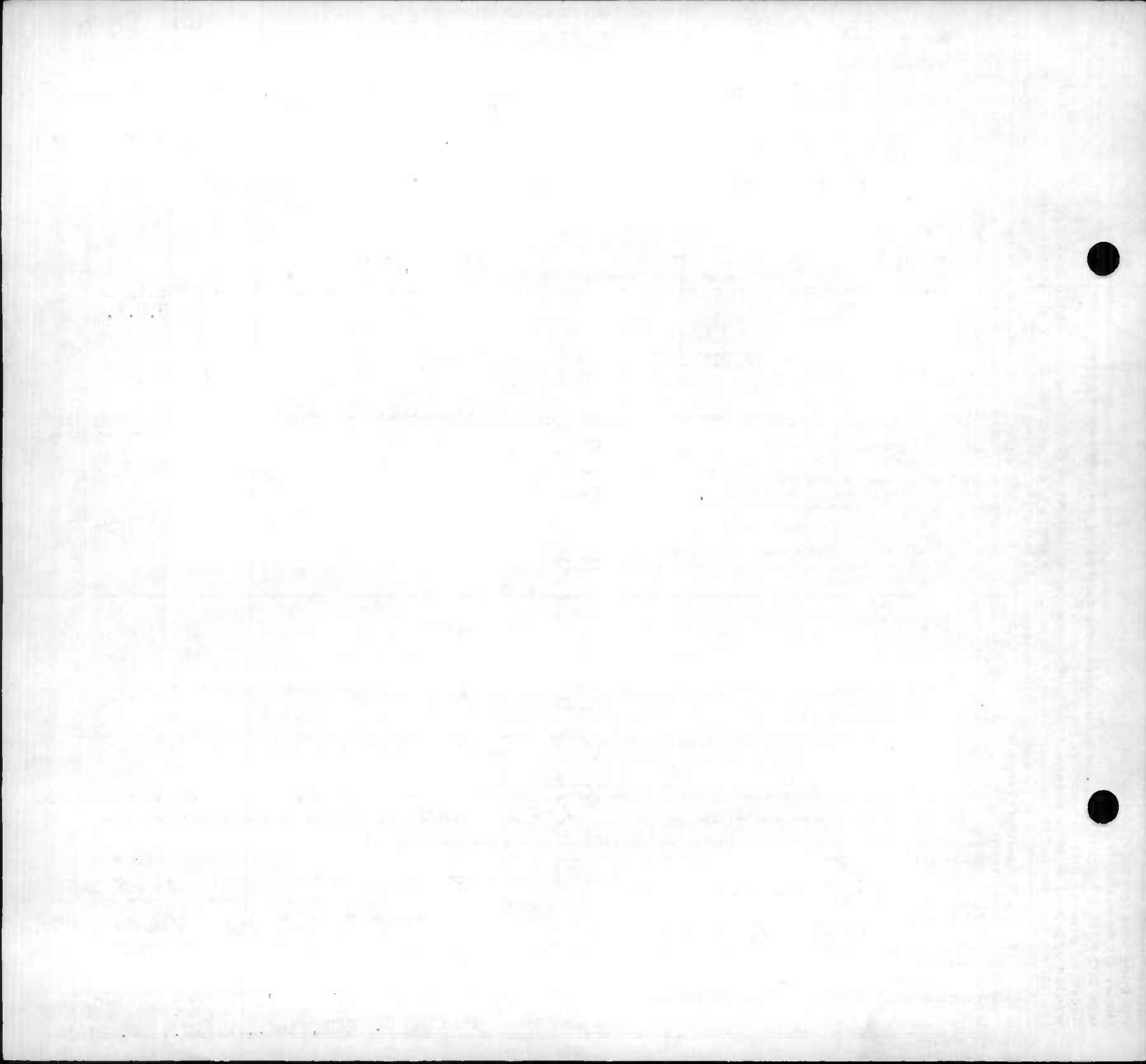
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0847					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 0847				
1. NAME OF DECEASED (Type or Print) Ernest A. Philipp Sr.					2. DATE AND HOUR OF DEATH January 25, 1965 6:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2706				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2922 Bayonne Avenue					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 2922 Bayonne Avenue				
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH Feb 12, 1891	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Philipp					14. MOTHER'S MAIDEN NAME Catherine Lentz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Amanda E. Philipp		ADDRESS same	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO La of lung (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6/64									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 06/64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED La of lung		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/23/65 1935 to 1/25/65 1965, that (I) (we) lost saw the deceased alive on 1/23/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Walter E. Karggin M.D.					23B. DATE SIGNED 1/25/65				
23C. PHYSICIAN'S NAME (Type) Walter E. Karggin M.D.					23D. ADDRESS 4331 Harford Road #14				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc			ADDRESS 5305 Harford Rd.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

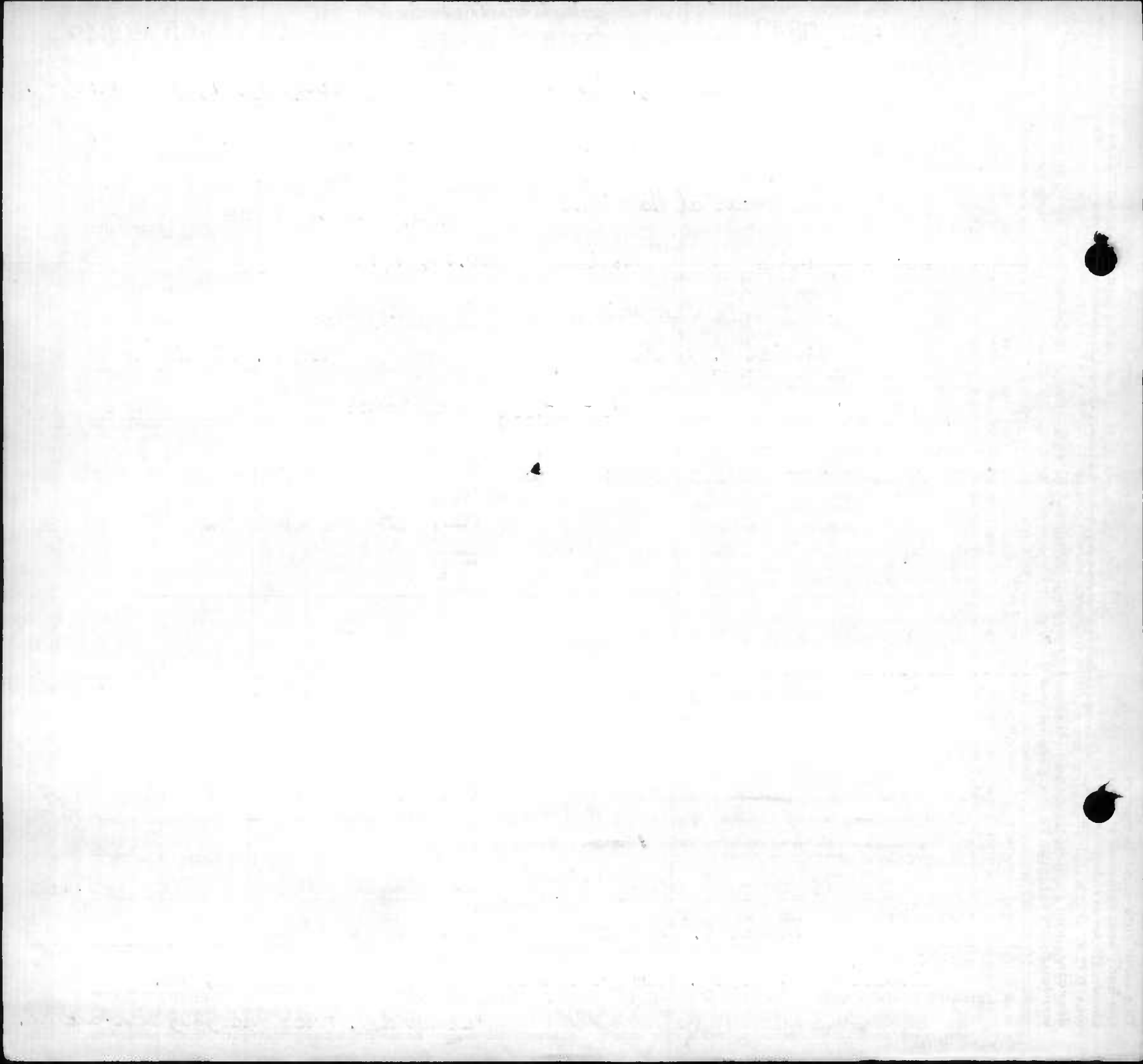
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0848	
BIRTH NO. 65 0848		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA(Annie) ABROMITES		2. DATE AND HOUR OF DEATH JANUARY 24, 1965 9 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 2845 LAKE AVENUE (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 2845 LAKE AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH JULY 26, 1875	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA	
13. FATHER'S NAME MATULEWICZ		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MISS MAMIE ABROMITES ADDRESS SAME	
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Hypertensive C.V.D. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 wk 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-23 1965 to 1-24 1965 , that (I) (we) last saw the deceased alive on 1-23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Duver Moore M.D. 23C. PHYSICIAN'S NAME (Type) J. DUVER MOORES				23B. DATE SIGNED 1-25-65 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23D. ADDRESS 3105 Belair Rd Balto 13 Md. M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/28/65		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214 ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

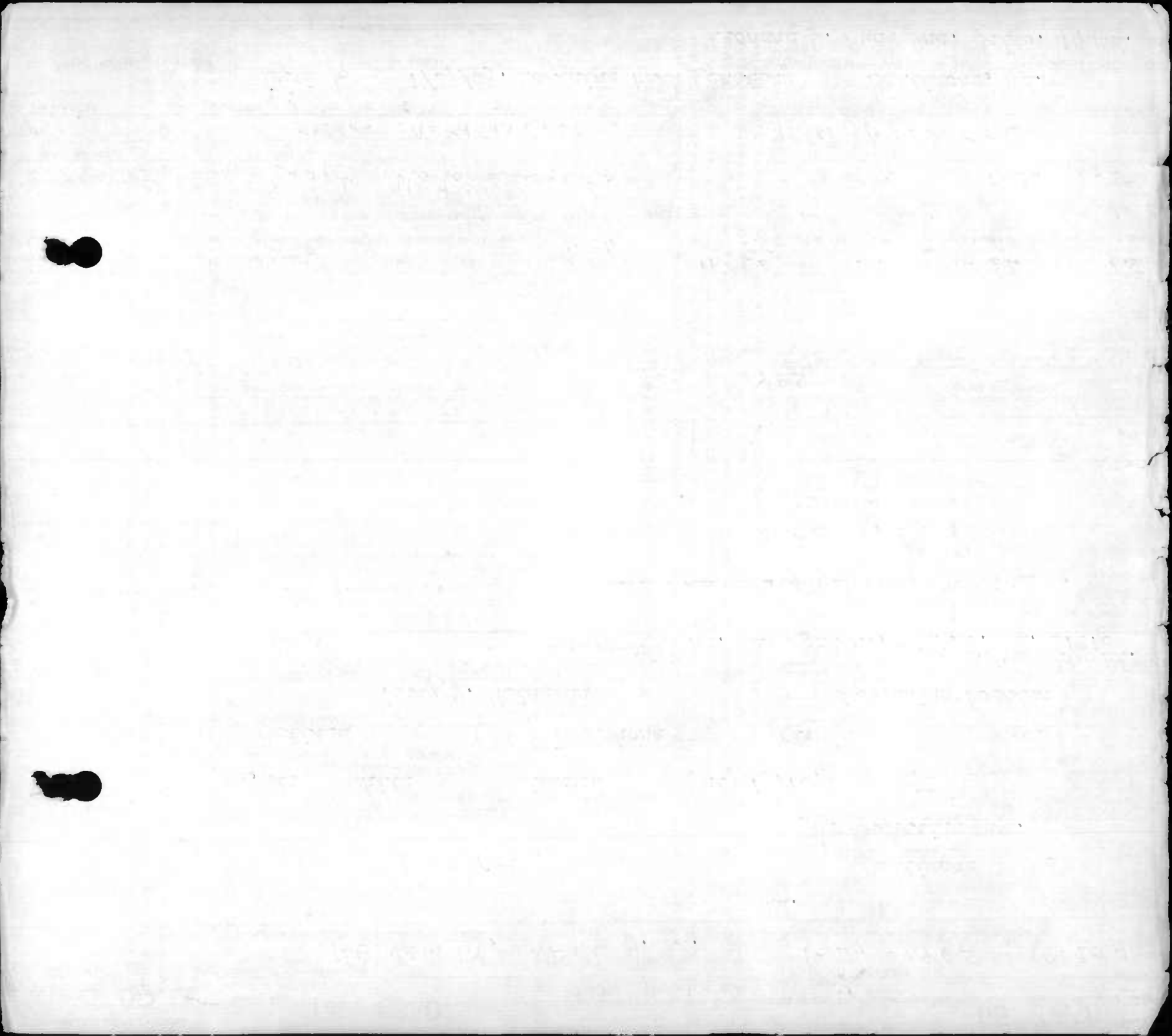
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0849	
BIRTH NO. 65 0849		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Vincent E. Coyne		2. DATE AND HOUR OF DEATH January 23, 1965 3:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: resident before admission) A. STATE Maryland B. COUNTY 2601 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6 D. STREET ADDRESS (If rural, give location) 4329 Berger Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Nov. 10, 1910	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamship Lines		11. BIRTHPLACE (State or foreign country) Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel J. Coyne				14. MOTHER'S MAIDEN NAME Mary M. Pittinger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-9359		17. INFORMANT Anne Coyne		ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Coronary Atherosclerosis (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (the deceased) attended the deceased from 6 Nov 1964 to 19 Dec 1964, that (1) (the deceased) last saw the deceased alive on 19 Dec 1964 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (the deceased) (did not) view the body after death.							
23A. SIGNATURE Thomas J. Brennan				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 23 Jan 1965	
23C. PHYSICIAN'S NAME (Type) Thomas J. Brennan				23D. ADDRESS M.D. 5217 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 0850	
BIRTH NO. 65 0850		CERTIFICATE OF DEATH								Registered No. 65 0850	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HEINEMAN, KARL J. Sr.						2. DATE AND HOUR OF DEATH 1-24-1965 10:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 502 Katherine Ave.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH July 13, 1892		9. AGE (In years last birthday) 72		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY C & P Telephone		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry J. Heineman						14. MOTHER'S MAIDEN NAME Wilhelmina Poehler					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-10-0584		17. INFORMANT ADDRESS Mrs. Mary Baltus, 3424 University Pl. Balto. Md. 21218					
18. 15 7X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) DUE TO Carcinoma of the pancreas (B) DUE TO with widespread metastases (C)			INTERVAL BETWEEN ONSET AND DEATH		
						II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. peritonitis -					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11-28 1964 to 1-24 1965, that (I) (we) last saw the deceased alive on 1-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Joseph Motarangelo M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-24-1965	
23C. PHYSICIAN'S NAME (Type) JOSEPH MOTARANGELO						23D. ADDRESS M.D. MERCY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14 Md.			



LS: 31-03-33
W3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0851

BIRTH NO. 65 0851

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Thomas B. Whiting Sr.

2. DATE AND HOUR OF DEATH

January 23, 1965 8:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE CORRECTED 1-28-65

FULL NAME OF HOSPITAL OR INSTITUTION

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3502 White Avenue #21214

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-8-75

9. AGE (In years
last birthday)

89

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland New Jersey

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas Whiting

14. MOTHER'S MAIDEN NAME

Louise Deacon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-74-7849

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

420.141 260 x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(A) Myocardial Infarction

Few Hours

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic Heart Disease

20 + Years

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

5 + Years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 17, 1964 to January 23, 1965, that (I) (we) last saw the deceased alive on January 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

January 23, 1965

23C. PHYSICIAN'S NAME (Type)

Dr. Richard Lane

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/27/65

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

25B. NAME OF REGISTRAR

E. E. Farley, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. 14, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from B.C.H.

1-28-65

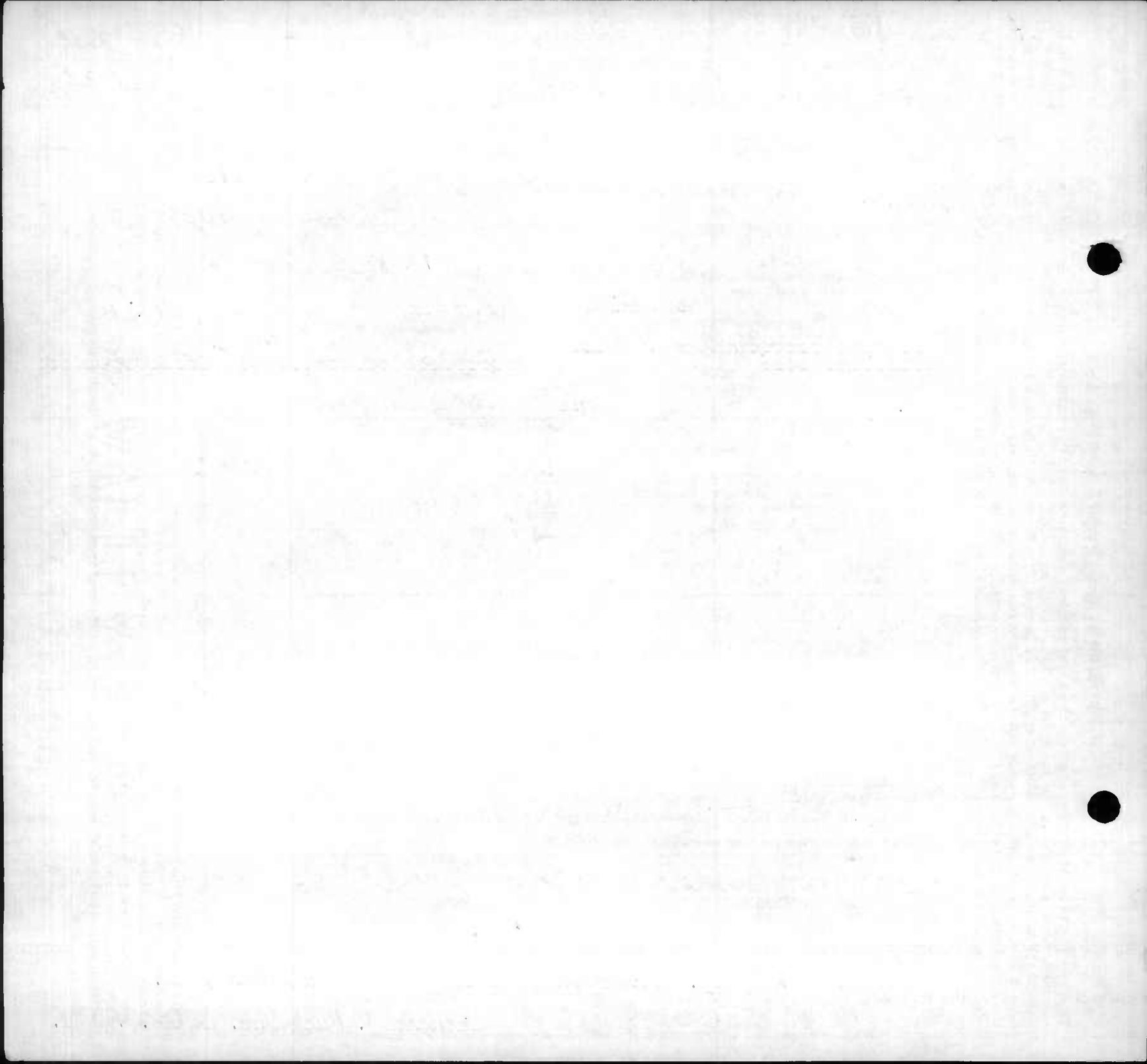
M.H.

Robert F. Kennedy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

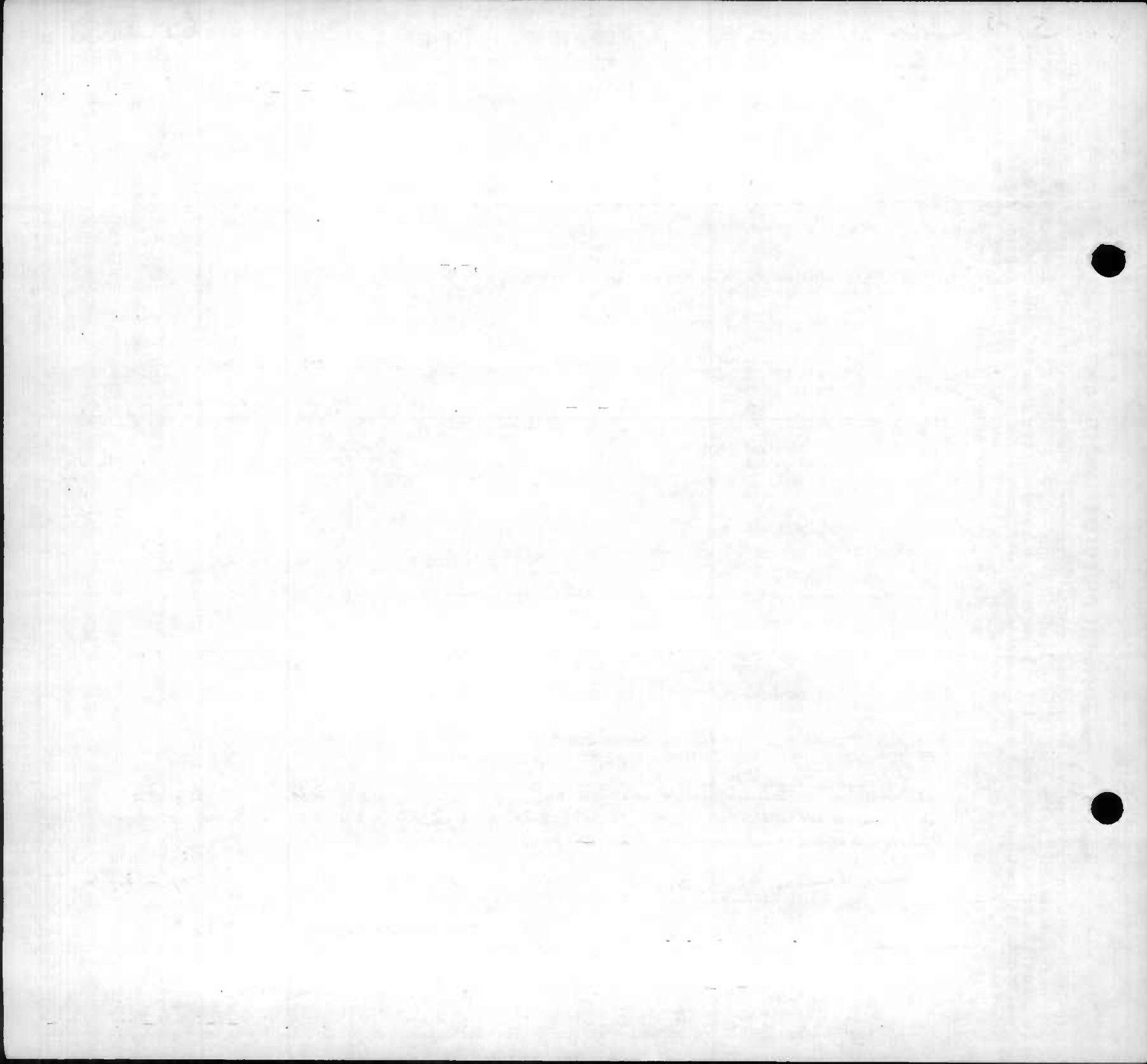
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 65 0852		
BIRTH NO. 65 0852						Certificate of Death BERLING		
1. NAME OF DECEASED (Type or Print) Elizabeth Catherine Bertling						2. DATE AND HOUR OF DEATH 1/24/65 4 55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 905		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for the Women of Md.						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #18		
						D. STREET ADDRESS (If rural, give location) 1120 Gorsuch Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 7/30/1888	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME xxxxxxx Andrew Huebler				14. MOTHER'S MAIDEN NAME xxxxxxx Mary Eppig				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Admission Street		
18. 4 20.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Gen. ASCVD (C) Arterial Occlusion, Rt. Leg.		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from January 1 19 65 to January 24 19 65 , that (I) (we) lost saw the deceased alive on January 24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE Diadema P. Simon, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-24-65		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto.		ADDRESS 14 Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0853	
BIRTH NO. 65 0853				M.E. CASE NO. 65 0853	
1. NAME OF DECEASED (Type or Print) YOW WONG (also DER BILL)			2. DATE AND HOUR OF DEATH Wed-Jan-20-1965 5:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Pines, 2525 Belvedere Av. (15)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5510 Minnoka Ave. (21215)		
5. SEX Male	6. RACE CHINESE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH -1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY restaurant	11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME could not ascertain			14. MOTHER'S MAIDEN NAME could not ascertain		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-32-6138	17. INFORMANT ADDRESS Jos. Der Quong, 5509 Reisterstown Road, (15)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 260X I Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 1 day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II Generalized Arterio-Sclerosis 4 years			(B) DUE TO Diabetes Mellitus 8 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 1956 to Jan 20 1965 , that (I) (we) last saw the deceased alive on Jan 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julius C. Gluck			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/22/65
23C. PHYSICIAN'S NAME (Type) Julius C. Gluck, M.D.			23D. ADDRESS M.D. 5356 Reisterstown Road # 15		
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT	24B. DATE Jan-25-65	24C. NAME of CEMETERY or CREMATORY Lorraine (Mausoleum)	24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS Stewart & Worn Co. 106-W-North-Av. City-1		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
BIRTH NO. 65 0854		65 0854	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mr. Frank E. STEWART		2. DATE AND HOUR OF DEATH 21 Jan. 1965 5:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 2-5-65 Maryland Gen. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 27-48	
5. SEX M		6. RACE W	
7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)		8. DATE OF BIRTH 16 March '85	
9. AGE (In years last birthday) 79		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Inspector Public Service Co.		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Stewart (dec)	
14. MOTHER'S MAIDEN NAME F. Nelson Umbach (dec)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 136-01-6643		17. INFORMANT Son Above	
18. 4-20-1 S.S. # 136-01-6983 CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		10-1 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 20 19 65 to Jan 21 19 65 that (I) (we) last saw the deceased alive on Jan 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE L. G. Tilley		23B. DATE SIGNED 21 January 1965	
23C. PHYSICIAN'S NAME (Type) L. G. Tilley		23D. ADDRESS M.D. Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65	
24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Talbot	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

V.S. 153

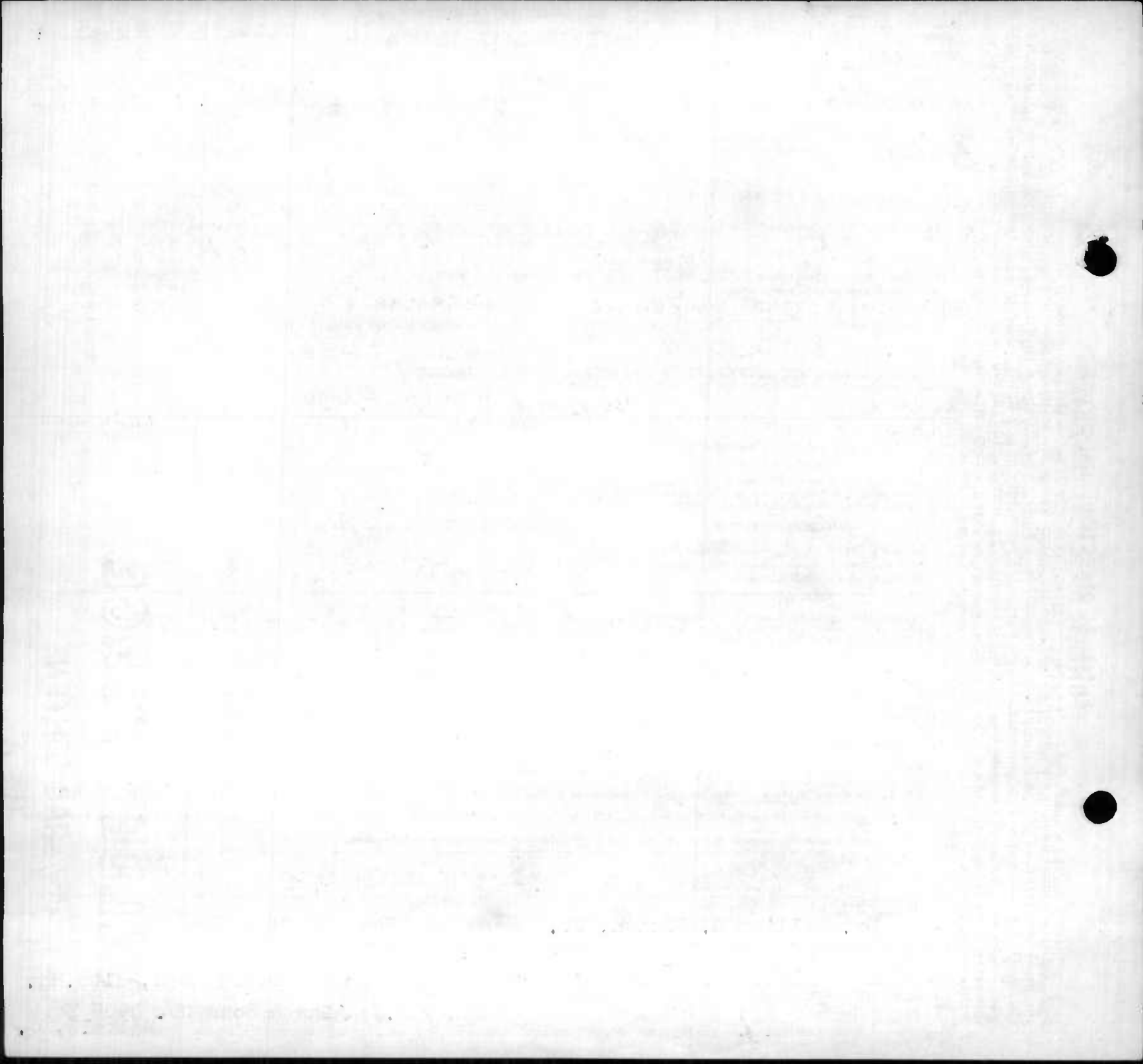
2-5-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 0855</u>				
BIRTH NO. <u>65 0855</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>WALTON, HENRY JANNEY, M.D.</u>					2. DATE AND HOUR OF DEATH <u>JANUARY 24, 1965 11:50 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>					A. STATE <u>MARYLAND</u>				
					B. COUNTY <u>12-01</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>3806 GREENWAY</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>1/14/79</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RADIOLOGIST (M.D.)</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>		11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>			12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>WILLIAM E. WALTON</u>					14. MOTHER'S MAIDEN NAME <u>ELLEN JANNEY</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>			16. SOCIAL SECURITY NO. <u>705-12-0780</u>		17. INFORMANT ADDRESS <u>HOSPITAL RECORDS</u>				
18. <u>451X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>RETROPERITONEAL HEMORRHAGE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>RUPTURED AORTIC ANEURYSM</u> <u>ARTERIOSCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Acute cholecystitis & subhepatic abscess</u>									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>1</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>JANUARY 23</u> 19 <u>65</u> to <u>JANUARY 24</u> 19 <u>65</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>JANUARY 24</u> 19 <u>65</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.									
23A. SIGNATURE <u>William R. Linton, Jr.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Dr. William R. Linton, Jr.</u>					23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/26/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Friends' Burial Grounds</u>			24D. LOCATION (City, town, or county) (State) <u>2506 Harford Road, Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Henry W. Jenkins & Sons Co. 4905 York Rd. Baltol2, Md.</u>				



1

65 0856

BALTIMORE CITY HEALTH DEPARTMENT

65 0856

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

59393

1. NAME OF DECEASED
(Type or Print)

LEO J. ASHLINE

2. DATE AND HOUR PRONOUNCED DEAD

January 24, 1965

6:42 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

202 N. Curley Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

2-2-1902

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Counterman Tool

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Kansas

12. CITIZEN OF
WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W. W. I

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dorothea R. Schultz

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

202 N. Curley Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 24 65 A.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
1/24/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-27-1965

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

H. W. Jenkins & Sons Co. 21212
4905 York Road Balto., Md.

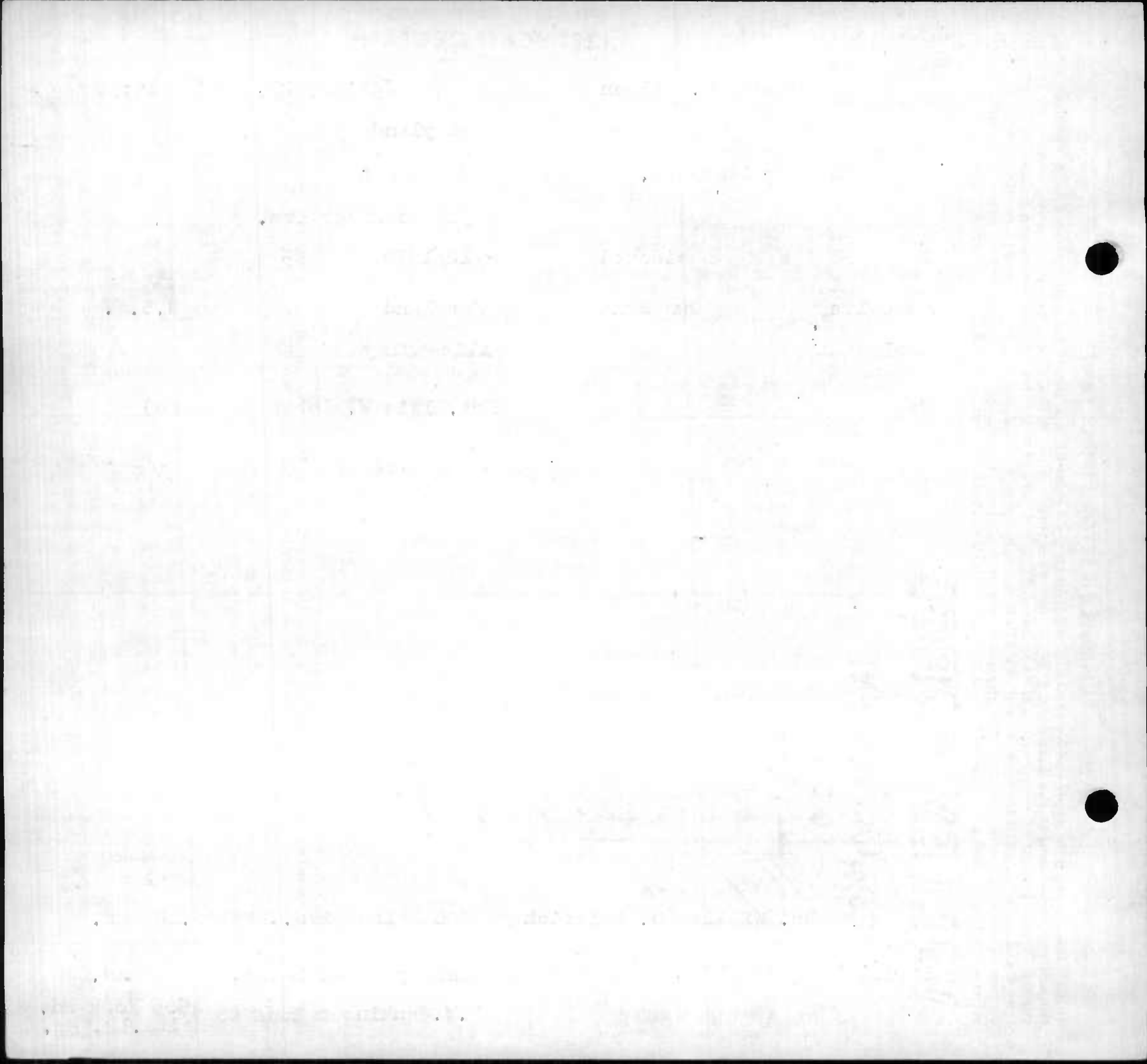
ADDRESS

6/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

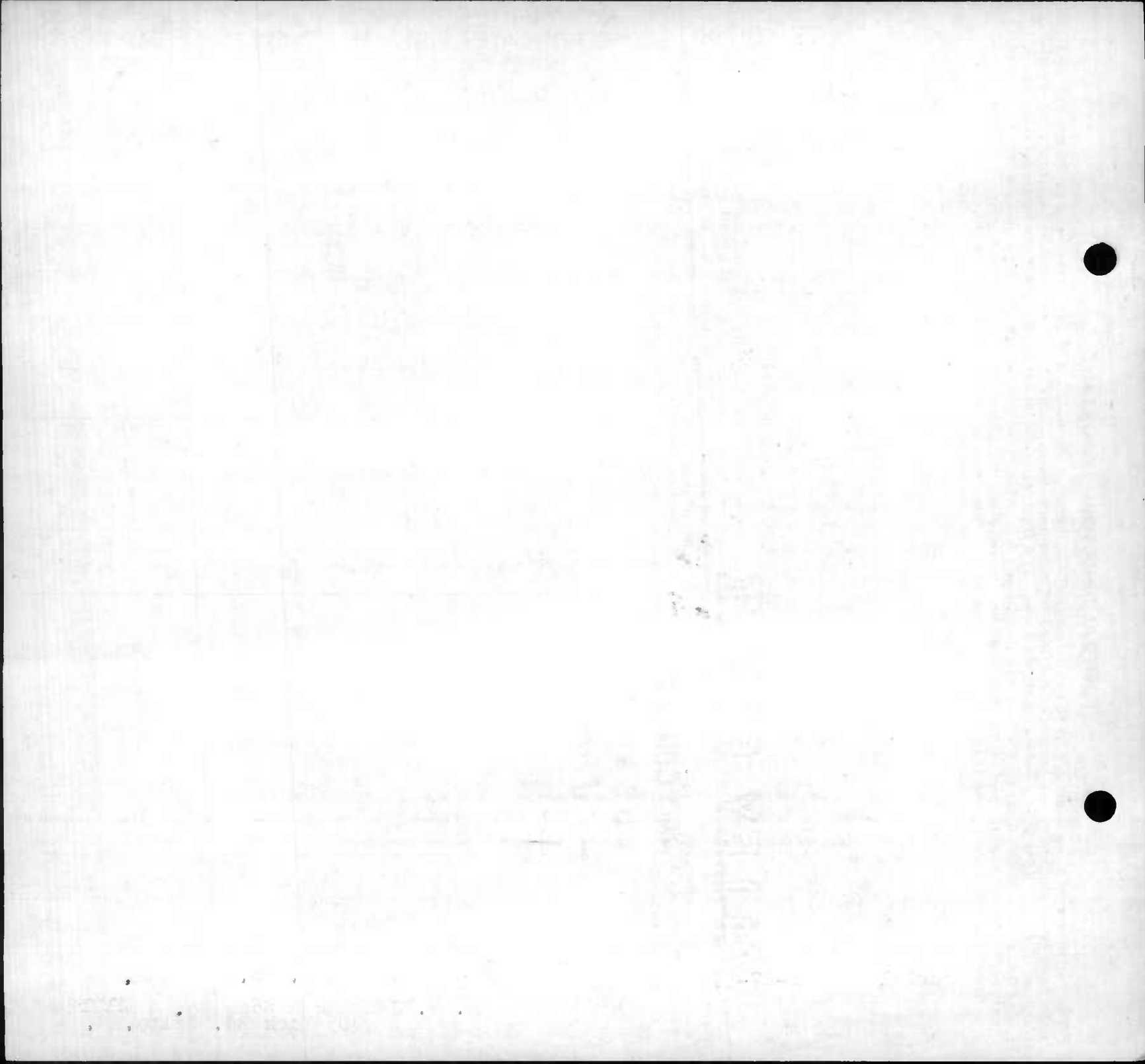
BIRTH NO. 65 0857		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 0857	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Geneva E. Wilson			January 22, 1965 10:30 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 310 Rossiter Ave.			A. STATE Maryland B. COUNTY 27-11		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 310 Rossiter Ave.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/12/1879	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Sapp			14. MOTHER'S MAIDEN NAME Alice Clay		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Elsie W. Lober (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH 4 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to January 19 65 , that (I) (we) last saw the deceased alive on 22 Jan 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. William G. Helfrich				23B. DATE SIGNED 1-23-65	
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich				23D. ADDRESS 5006 Roland Ave., Balto. 10 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farkas, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

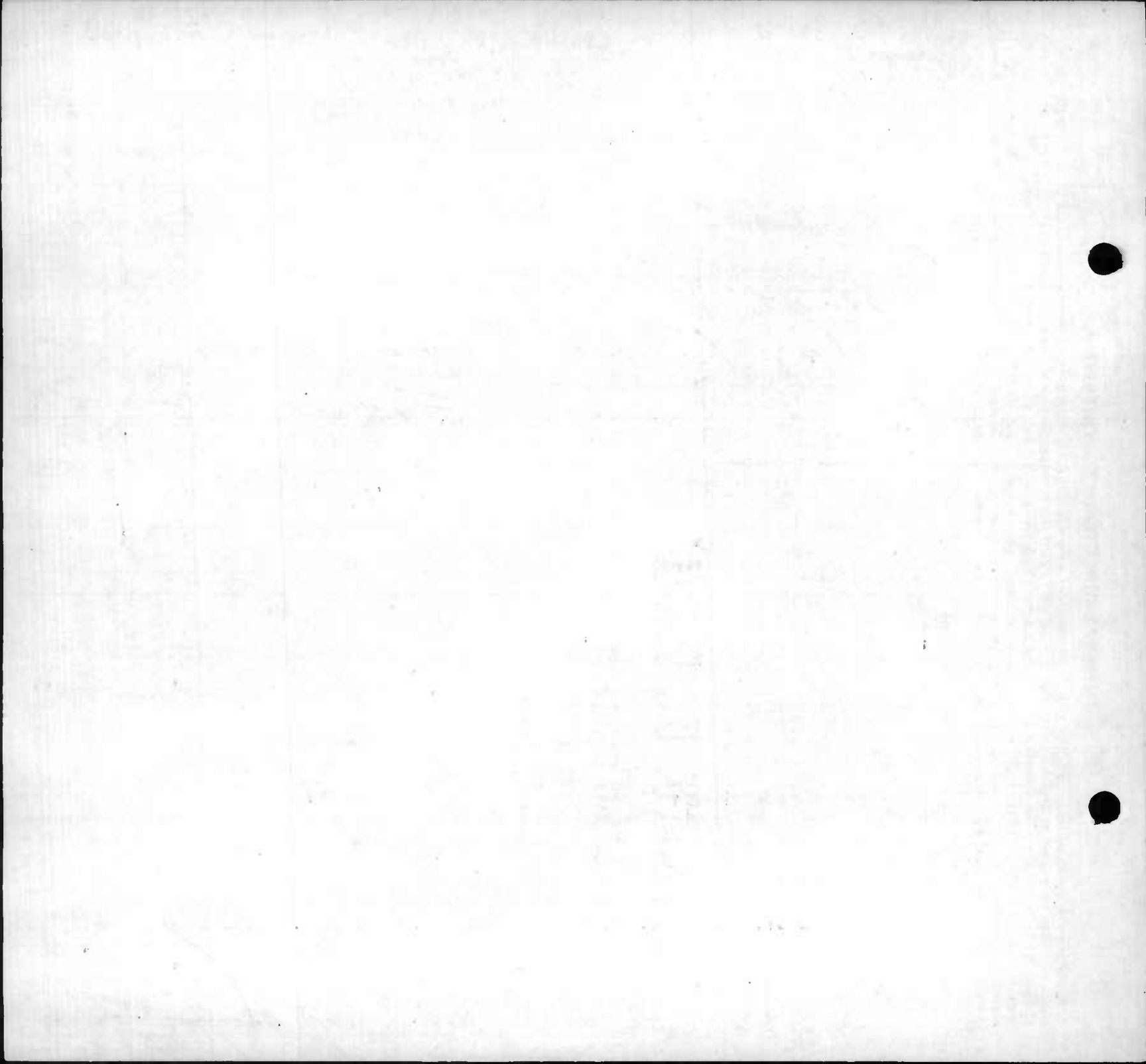
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. X 65 0858	
BIRTH NO. 65 0858					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Lydia Seidel Eierman		2. DATE AND HOUR OF DEATH 10⁴⁰ PM 1/23/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL Hospital		A. STATE MARYLAND B. COUNTY 53-00			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 619 Regester Avenue			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 8/11/97	9. AGE (in years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HENRY J. SEIDEL		14. MOTHER'S MAIDEN NAME BARBARA ZINK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT (Husband) J. FRED EIERMAN ADDRESS (SAME)	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTESTINAL Obstruction 1 month		(B) DUE TO			
		(C) ADENOCARCINOMA of COLON		2 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1/11/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL Obstruction		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 12/23 19 64 to 1/23 19 65 , that (I) was last saw the deceased alive on 1/23 19 65 and that in (my) the opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE William N. Bennett		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/23/65	
23C. PHYSICIAN'S NAME (Type) William N. BENNETT		23D. ADDRESS M.D. Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1965		24C. NAME OF CEMETERY or CREMATORY Cemetery Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

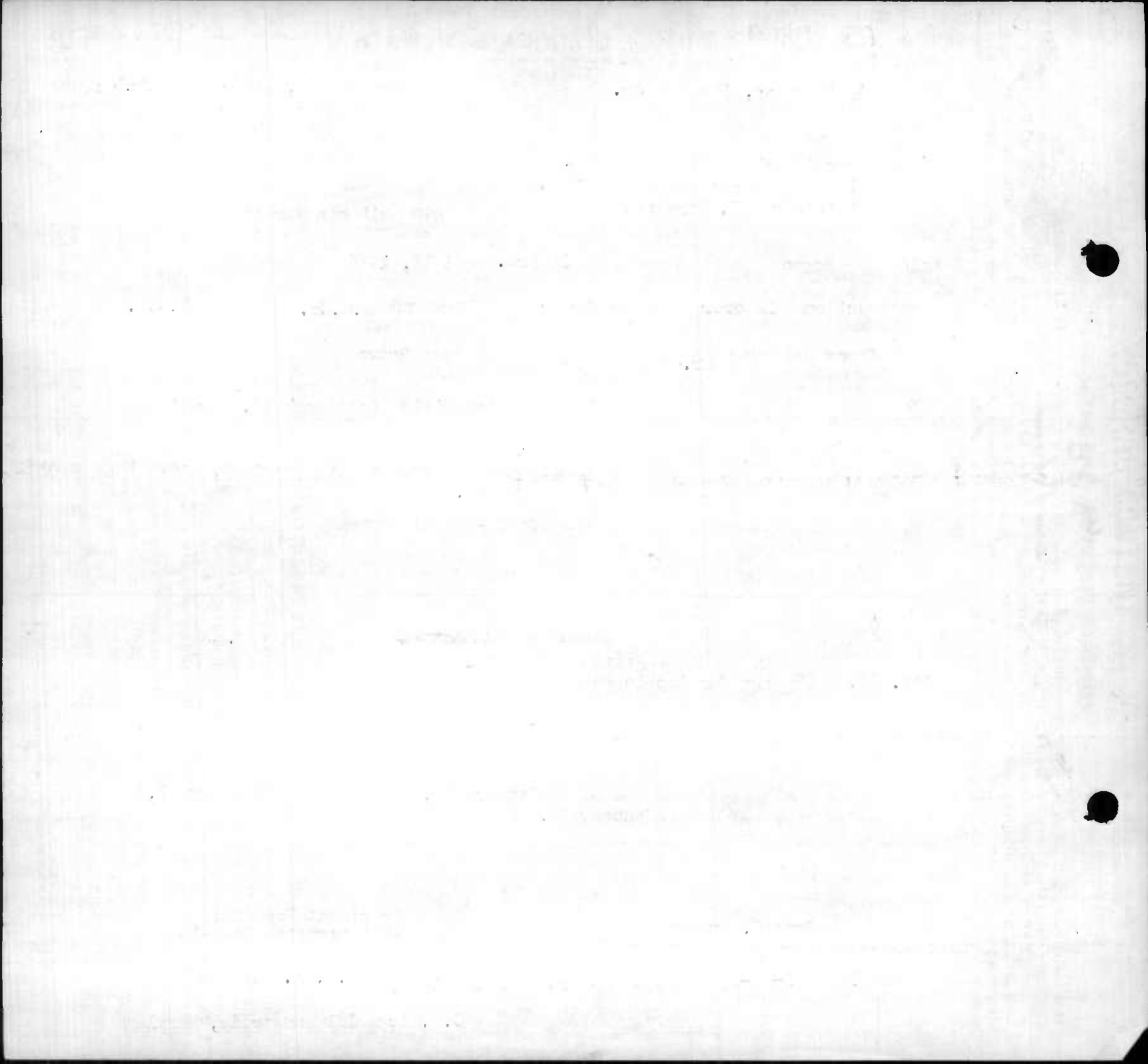
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0859	
BIRTH NO. 65 0859							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) William Blanche Wilkinson		2. DATE AND HOUR OF DEATH 1-13-65 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 409 Patapsco Ave.		(If not in hospital or institution, give street address or location)		A. STATE Ind. B. COUNTY 25-04			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 409 Patapsco Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W		8. DATE OF BIRTH 11-14-81	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chas. Barker				14. MOTHER'S MAIDEN NAME Emma McKimmon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family - Same ADDRESS			
18. 420.1 I		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		Angina Pectoris				6 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Coronary Sclerosis					
		(B) DUE TO					
		(C) DUE TO					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 1959 to Jan 23, 1965 , that (I) (we) last saw the deceased alive on Jan 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Louis J. Glass M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) DOCTOR LOUIS J. GLASS M.D.				23D. ADDRESS 320 PATAPSCO AVE. BALTIMORE MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Barto.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR McE...		ADDRESS 237 Patapsco Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0860</u>	
BIRTH NO. <u>65 0860</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Galloway, James Jr.</u>		2. DATE AND HOUR OF DEATH <u>January 17, 1965</u> <u>2:20a</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-02</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore 17, Maryland</u>		D. STREET ADDRESS (If rural, give location) <u>620 Smithson Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated 10 yrs.</u>	8. DATE OF BIRTH <u>April 15, 1916</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland A.A.Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Galloway Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Brown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>1532 Druid Hill Avenue</u> <u>Sam Fields Baltimore 17, Maryland</u>	
18. <u>575 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Severe Septicemia with Adynamic ileus.</u>		CAUSE OF DEATH (A) <u>Severe Septicemia with Adynamic ileus.</u> (B) <u>Ischio-rectal Abscess</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>more than a week</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>Jan. 15, 1965</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>incision and drainage for ischio-rectal abscess</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1965</u> to <u>January 17, 1965</u> , that (I) (we) last saw the deceased alive and <u>January 17, 1965</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jose C. Arroyo</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 17, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jose C. Arroyo</u>		23D. ADDRESS <u>Provident Hospital</u> <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-22-65</u>	24C. NAME OF CEMETERY or CREMATORY <u>Chews Church (Methodist)</u>		24D. LOCATION (City, town, or county) (State) <u>A.A.Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>C.E. Hicks 111 Annapolis, Maryland</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

40

B-6201

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0861				
BIRTH NO. 65 0861		M.E. CASE NO.			2. DATE AND HOUR OF DEATH 1-24-65 8:45P M.				
1. NAME OF DECEASED (Type or Print) BERG, RUBY E.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2504				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL <small>If not in hospital or institution, give street address or location</small>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3723 BROOKLYN AVE. #25				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED <small>WIDOWED, DIVORCED (specify)</small>		8. DATE OF BIRTH 12-25-22 <small>(lost birthday)</small>	9. AGE (In years) 42 <small>(lost birthday)</small>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNK				14. MOTHER'S MAIDEN NAME UNK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS; BALTO 29					
18. 433.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
					(A) congestive heart failure 2 hrs DUE TO		(B) due to cardiac arrhythmia 4 hrs DUE TO		
					(C) arteriosclerotic cardiovascular dis. w/				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <small>If in Baltimore City, give exact location</small>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 24 1965 to JANUARY 24 1965 , that (I) (we) last saw the deceased alive on JANUARY 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. D. D'Arcy M.D.					Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-24-65		
23C. PHYSICIAN'S NAME (Type) DR. F. D'ARCY				23D. ADDRESS M.D. ST. AGNES HOSPITAL; BALTO 29, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/28/65		24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Ruby E. Fisher, M.D.		25C. FUNERAL DIRECTOR MCCULLY FUNERAL HOME		ADDRESS 237 PATAPSCO AVE.			

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

1987-1988

1989-1990

1991-1992

1993-1994

1995-1996

1997-1998

1999-2000

2001-2002

2003-2004

2005-2006

2007-2008

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0862

BIRTH NO. 65 0862

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) ROSE L. AKERS

2. DATE AND HOUR OF DEATH

1/23/65

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

SBGH

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

59 TALBOT ST

5. SEX
F

6. RACE
W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH
2/15/91

9. AGE (In years last birthday)
73

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WILLIAM LLOYD

14. MOTHER'S MAIDEN NAME

ELIZ. LEIBOLD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

FAMILY

ADDRESS

SAME

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10:15 to 1:20, that (I) (we) last saw the deceased alive on 1/22/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1-25-65

23C. PHYSICIAN'S NAME (Type)

R. E. Summers

23D. ADDRESS

M.D.

1101 Pat. Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/27/65

24C. NAME OF CEMETERY or CREMATORY

GLEN HAVEN CEM

24D. LOCATION

(City, town, or county)

(State)

GLEN BURNIE, MD.

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

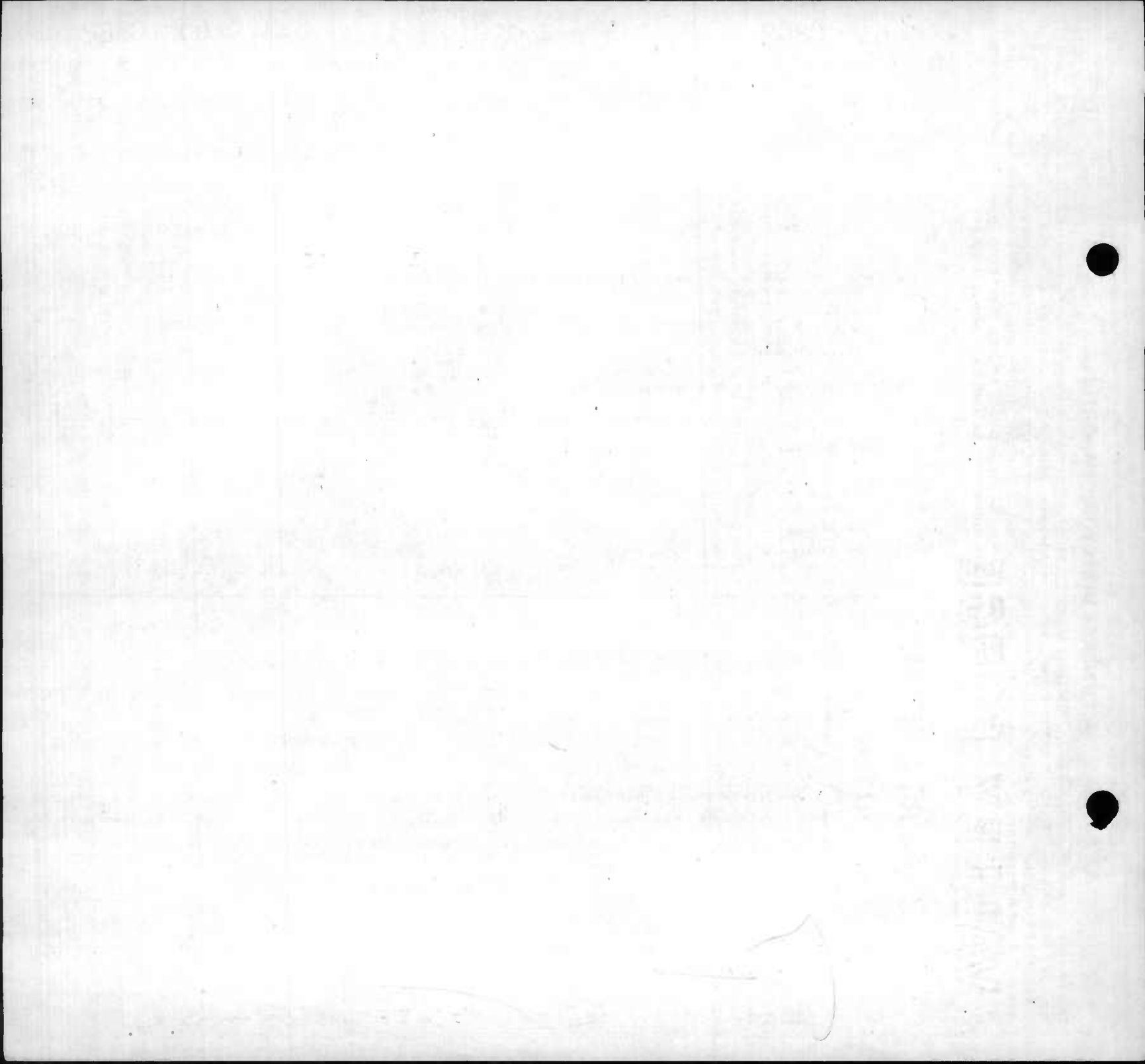
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

McCULLY FUNERAL HOME 237 Pat. Ave.

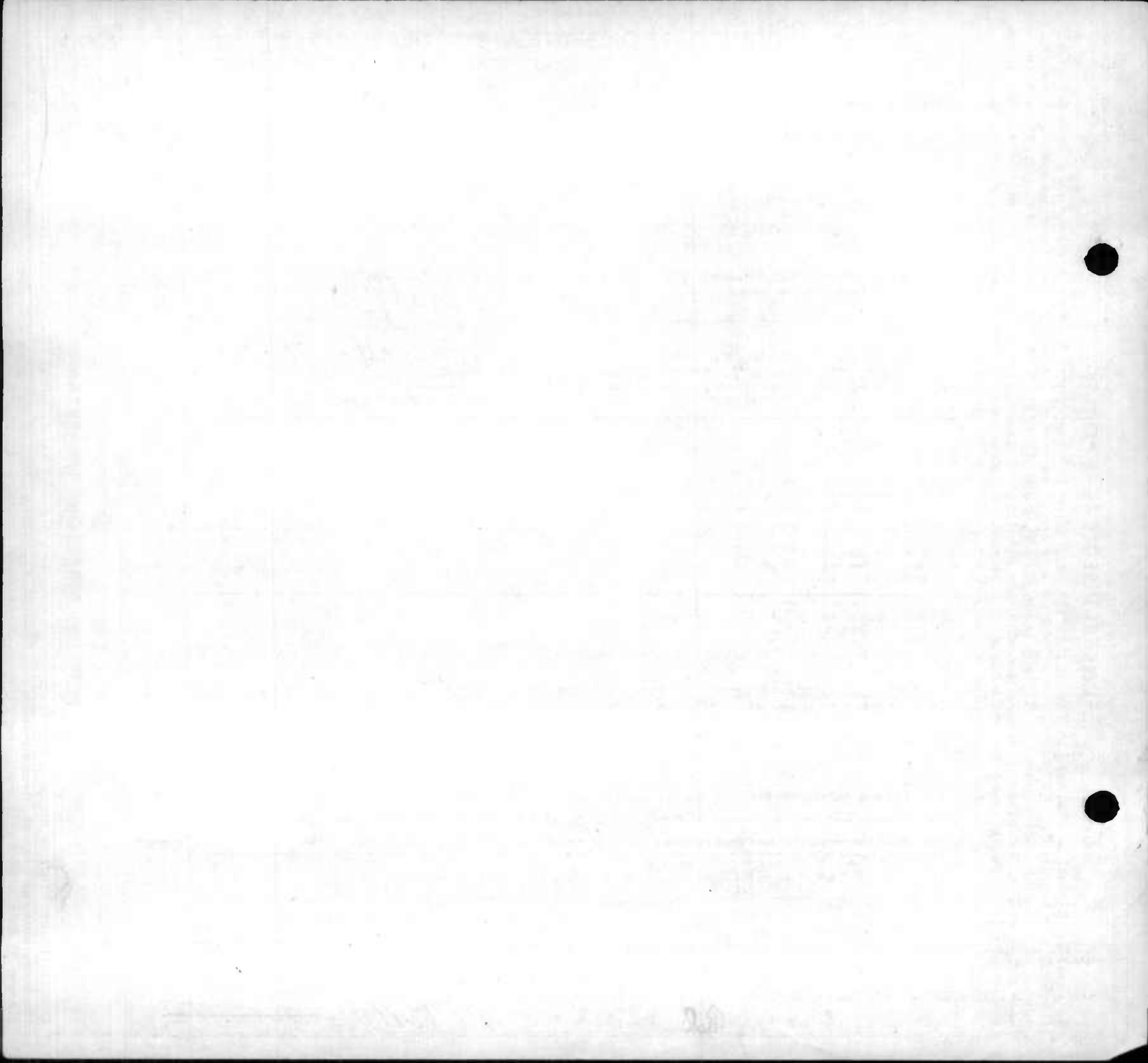
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

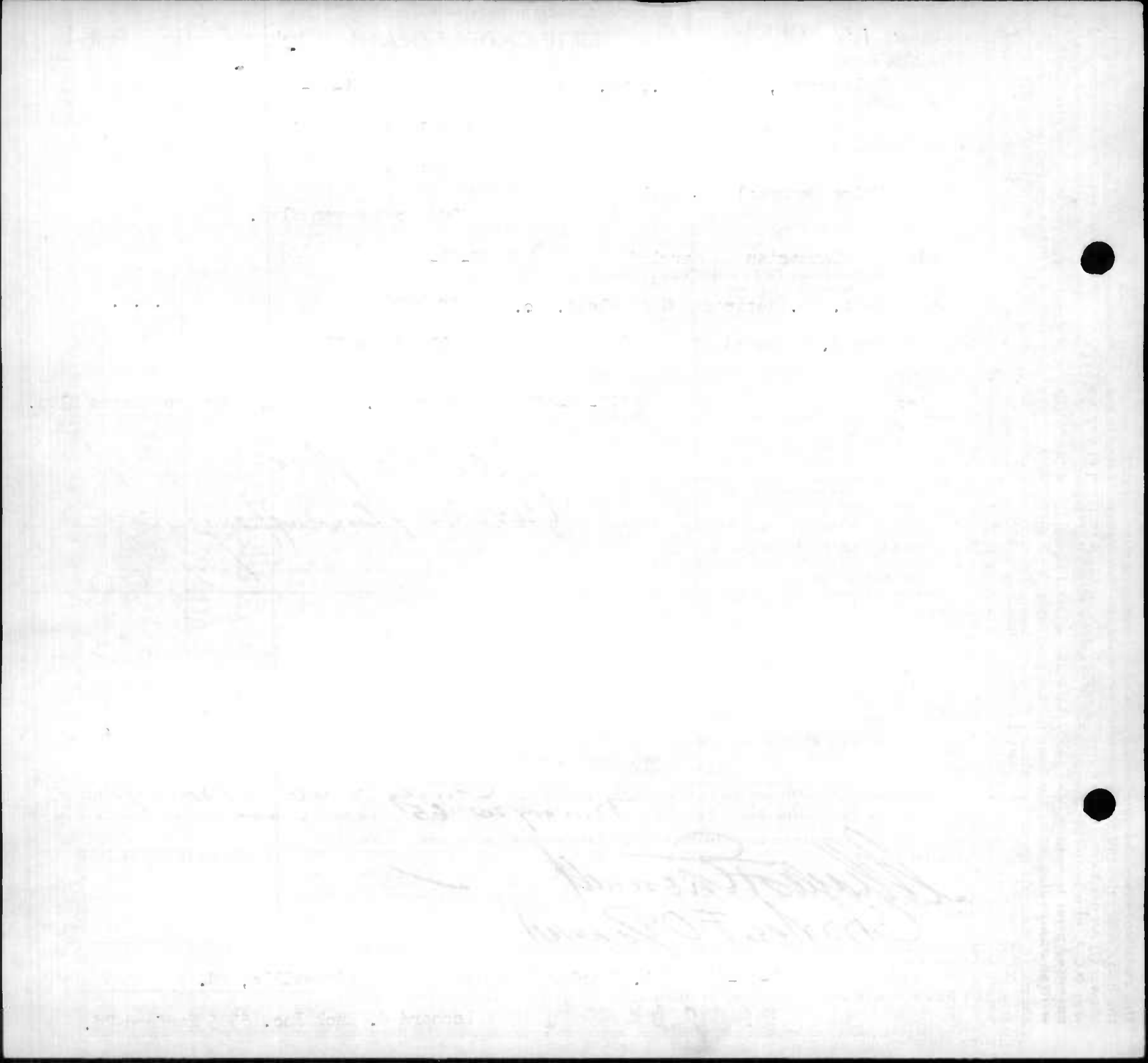
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 0863</u>	
BIRTH NO. <u>65 0863</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>James Russell Norman</u>				2. DATE AND HOUR OF DEATH <u>1/23/65</u> <u>4:00 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>9.9. Co</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Ferndale</u> <u>52-00</u>			
				D. STREET ADDRESS (If rural, give location) <u>11 Cromwell Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/12/65</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Real estate</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Norman</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Hopkins</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family - Jane</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Ventricular Fibrillation</u> DUE TO (B) <u>Myocardial Infarction</u> DUE TO <u>23 days</u> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/10/65</u> to <u>1/23</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jonathan Tuerk</u>				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/23/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jonathan Tuerk MD</u>				23D. ADDRESS M.D. <u>University Hospital</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>1-27-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge</u>		24D. LOCATION (City, town, or county) (State) <u>Baeto</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCully & Sons</u>		ADDRESS <u>237 Oak Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0864	
BIRTH NO. 65 0864		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Langgood, Charles J., Sr.		2. DATE AND HOUR OF DEATH 1-22-65 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5708 Loch Raven Blvd.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-20-95	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas & Elect. Co. Retired		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elect. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles J. Langgood				14. MOTHER'S MAIDEN NAME Ellen Connelly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 212-05-6573A		17. INFORMANT ADDRESS Margaret E. Langgood, 5708 Loch Raven Blvd.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Coronary Insufficiency (C) 16 yr. 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 3, 1956 to January 22, 1965 , that (I) (we) last saw the deceased alive on January 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles F. O'Donnell M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65		24C. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0865	
BIRTH NO. 65 0865				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ETTINGER, JOHN WILLIAM				1-21-65 3:40P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL				A. STATE MARYLAND	
(If not in hospital or institution, give street address or location)				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) KINGSVILLE	
				D. STREET ADDRESS (If rural, give location) SUNSHINE AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7-10-52	9. AGE (In years last birthday) 12	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE (STUDENT)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN W. Ettinger, Sr.		
14. MOTHER'S MAIDEN NAME HELEN NEUNER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT ST. AGNES HOSPITAL RECORDS; WILENS & CATON AVES		
18. 1930 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RECURRENT Malignant Brain Tumor			CAUSE OF DEATH (A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 20 19 65 to JANUARY 21 19 65, that (I) (we) last saw the deceased alive on JANUARY 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Winfredo N. Iglesias M.D.				23B. DATE SIGNED 1-21-65	
23C. PHYSICIAN'S NAME (Type) DR. W.N. IGLESIA				23D. ADDRESS ST. AGNES HOSPITAL, BALTO 29, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/25/65	24C. NAME OF CEMETERY or CREMATORY Fork Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Fork, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR R. L. E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruak, 5305 Hyford Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

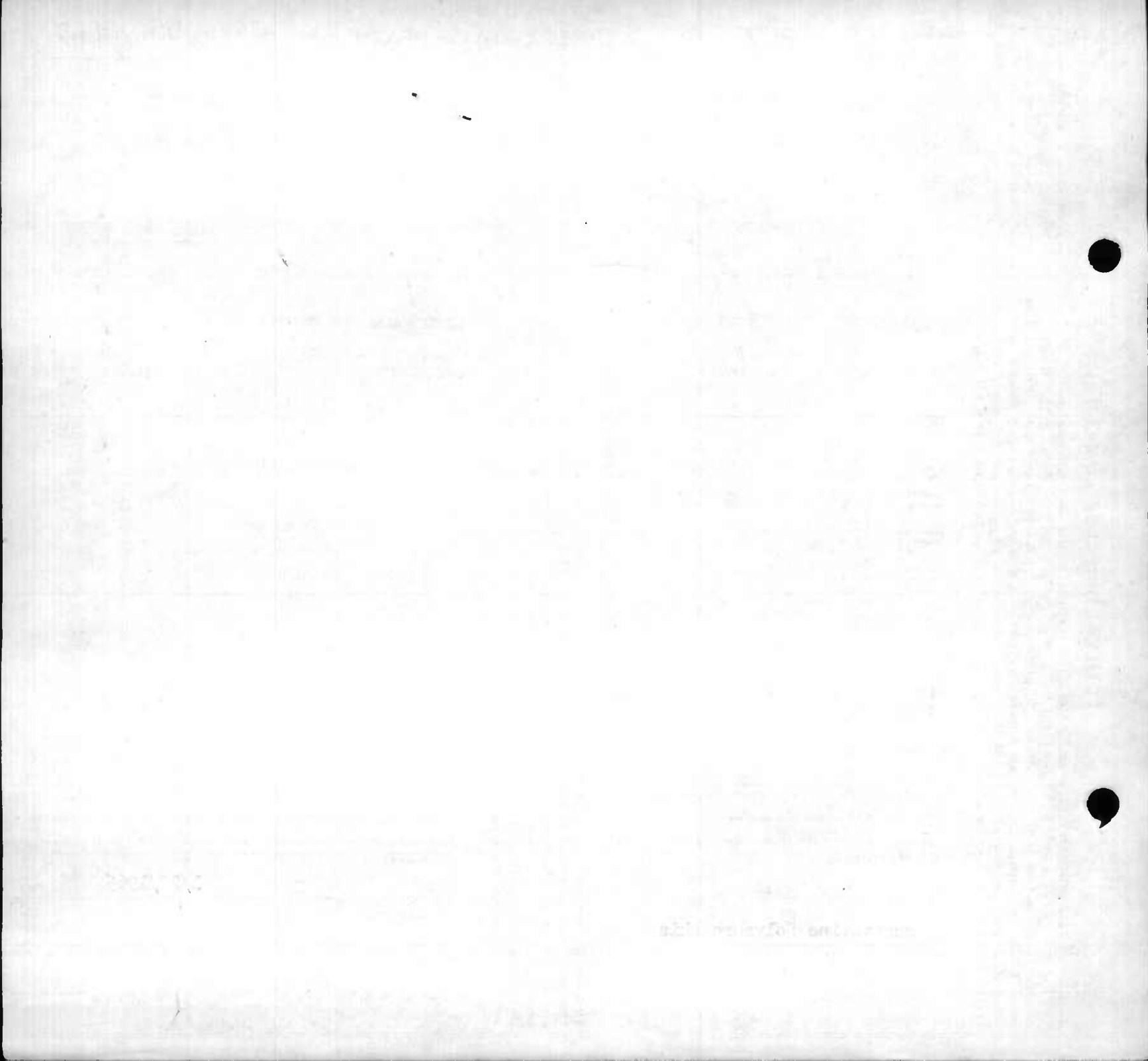
BIRTH NO. 65 0866				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0866	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BARRETT, THOMAS (NMI)				2. DATE AND HOUR OF DEATH January 21, 1965 10:00 A.M. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 6-7-65 HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5501 Hamlett Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/5/87	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Barrett				14. MOTHER'S MAIDEN NAME Anna Lauehardt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/28/18-5/19/19			16. SOCIAL SECURITY NO. 216 12 2421		17. INFORMANT VA Hospital Records, 3900 Loch Raven Blvd Baltimore, Maryland 21218		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 491X I Bronchopneumonia (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardiovascular Disease Bronchopneumonia Acute Pericarditis						4 years 3 days unknown	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (if) (this hospital) attended the deceased from January 18th 19 65 to January 21st 19 65 , that (if) (we) last saw the deceased alive on January 21st 19 65 and that in (if) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (if) (view) the body after death.							
23A. SIGNATURE Anastacio Hoyumpa, M.D.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/21/65	
23C. PHYSICIAN'S NAME (Type) ANASTACIO HOYUMPA, M.D.				23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Boulevard Balto., Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/25/65		24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214		ADDRESS	

Letter from Vet. Admn. Hospital
6-7-65 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

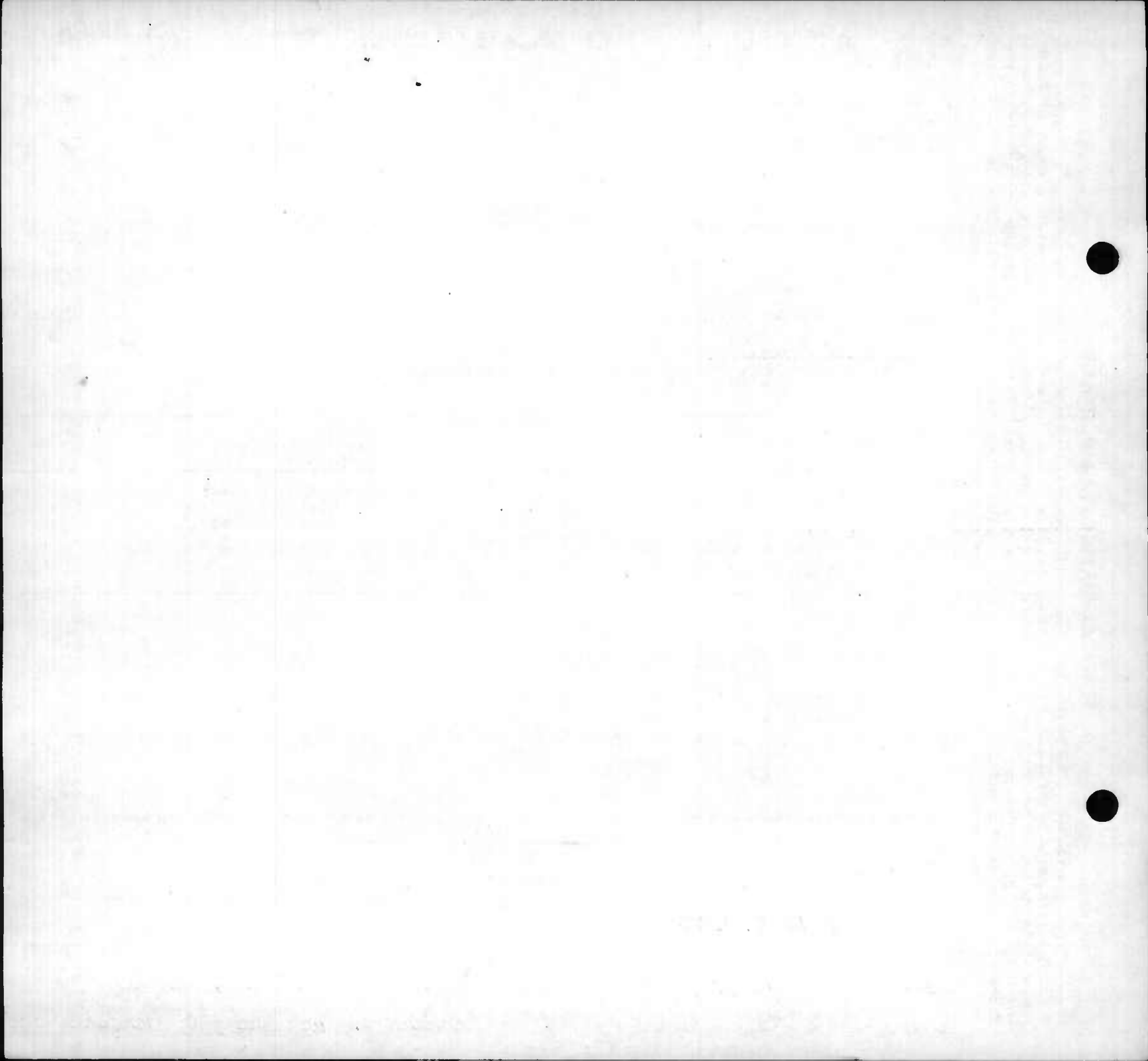
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0867					CERTIFICATE OF DEATH		Registered No. 65 0867		
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>O'Malley Edward P.</i>					1/22/1965 2:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secour Hospital</i>					A. STATE <i>Maryland</i> B. COUNTY <i>9-05</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 18</i>				
					D. STREET ADDRESS (If rural, give location) <i>1111 Gorsuch Ave #18</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i>	8. DATE OF BIRTH <i>11/14/93</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Bethlehem Steel</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John O'Malley</i>			14. MOTHER'S MAIDEN NAME <i>Margaret McDonald</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>213-07-7530</i>		17. INFORMANT ADDRESS <i>Miss Margaret O'Malley</i>				
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Generalized Carcinoma of Lung</i> (B) (C) INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>1-9-1965</i> to <i>January 22, 1965</i> , that (I) (we) last saw the deceased alive on <i>January 22, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Constantine Polychronakis</i>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/22/1965</i>		
23C. PHYSICIAN'S NAME (Type) <i>Constantine Polychronakis</i>					23D. ADDRESS M.D.				
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1-25-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Park</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Edward J. Rusk</i>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 0868					CERTIFICATE OF DEATH					Registered No. 65 0868									
M.E. CASE NO. 65 0868					1. NAME OF DECEASED (Type or Print) SVERRE B. RAMSLAND					2. DATE AND HOUR OF DEATH 1/22/65 12:05 a.m.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-01					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital					D. STREET ADDRESS (If rural, give location) 3217 Berkshire Rd														
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12/29/02		9. AGE (In years last birthday) 62		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Norway					12. CITIZEN OF WHAT COUNTRY? American				
13. FATHER'S NAME Sigvart Ramsland					14. MOTHER'S MAIDEN NAME Marie Svensen														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Mrs. Thordis Ramsland					ADDRESS				
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Myocardial infarct, recent DUE TO (B) Severe coronary arteriosclerosis DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (A) (this hospital) attended the deceased from 1/21/1965 to 1/22/1965, that (B) (we) last saw the deceased alive on 1/23/1965 and that in (C) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.																			
23A. SIGNATURE William B. Long					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 1/22/65									
23C. PHYSICIAN'S NAME (Type) WILLIAM B. LONG					23D. ADDRESS M.D. The Union Memorial Hospital														
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation					24B. DATE 1/25/65					24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965					25B. NAME OF REGISTRAR Robert E. Fisher, M.D.					25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Road					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Michael Maistros
314 2617

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0869	
65 0869				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MICHAEL MAISTROS				1-22-65 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY		
			D. STREET ADDRESS (If rural, give location) 140 SOUTH ELLWOOD AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-27-93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Chios, Greece	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE MAISTROS		14. MOTHER'S MAIDEN NAME Angela Capous	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 293-16-9149		17. INFORMANT Mrs. Artemis Maistros, 140 S. Ellwood Ave, Baltimore, Md. 21224	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 1 d		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22 1965 to 1/22 1965 that (I) (we) last saw the deceased alive on 1/22 1965 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.P. Kokko M.D.				23B. DATE SIGNED 1/22/65	
23C. PHYSICIAN'S NAME (Type) J.P. Kokko M.D.				23D. ADDRESS Johns Hopkins	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			
25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Ave, Baltimore, Md. 21224			
25D. ADDRESS					

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W. H. H.

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P-632

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

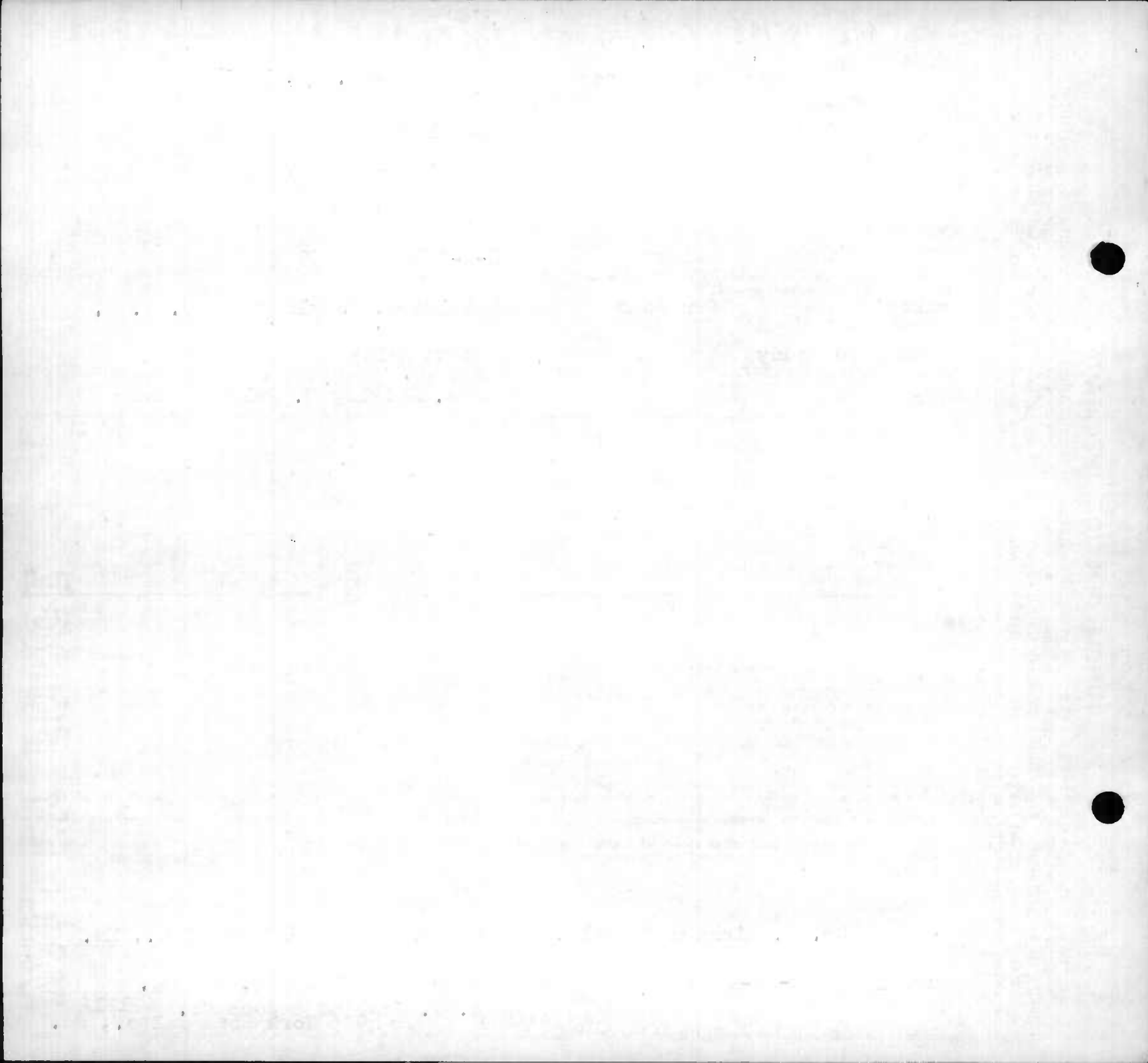
BIRTH NO.		M.E. CASE NO. 59396		1. NAME OF DECEASED (Type or Print) SAMUEL B. PORTS		2. DATE AND HOUR PRONOUNCED DEAD January 24, 1965 5:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital				A. STATE Maryland B. COUNTY			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-02			
				D. STREET ADDRESS (If rural, give location) 1242 Cleveland Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-30-27	9. AGE (In years last birthday) 37	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel B. Ports Sr.				14. MOTHER'S MAIDEN NAME Anna Dowling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1946		16. SOCIAL SECURITY NO. 215226608		17. INFORMANT ADDRESS Pauline Ports - Above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) Craniocerebral Injury. DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wicomico St., W. of Bayard St. 21-02			
21D. TIME OF INJURY (APPROX.) 1 22 '65 P.		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR? Driver of auto into parked box car.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 1/24/65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-27-65		23C. NAME OF CEMETERY or CREMATORY Mt. Olivet		23D. LOCATION (City, town, or county) (State) Balto Md.	
24A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR John J. Cowan & Son Inc.		ADDRESS Balto Md.	

6/2/59

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 65 0871						
BIRTH NO. 65 0871		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Susan Roddy Herzer			2. DATE AND HOUR OF DEATH Jan. 24, 1965 2 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 202 Upnor Road					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 202 Upnor Road						
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 2-5-1885		9. AGE (In years last birthday) 79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Bernard Roddy					14. MOTHER'S MAIDEN NAME Susan Lally						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Shirley H. Feldman			ADDRESS Same	
18. 422-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral vascular accident DUE TO (B) arterio-sclerotic cardiac vascular disease DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 16 hours 15 years											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION D			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 19 57 to Jan 23, 19 65 , that (I) (we) last saw the deceased alive on Jan 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE C. Richard Fravel M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/25/65		
23C. PHYSICIAN'S NAME (Type) Dr. C. Richard Fravel						23D. ADDRESS M.D. Medical Arts Building Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1-26-1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			25B. NAME OF REGISTRAR Robert E. Farkley, M.D.			25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 21212 4905 York Road Balto., Md.					



1
L-400

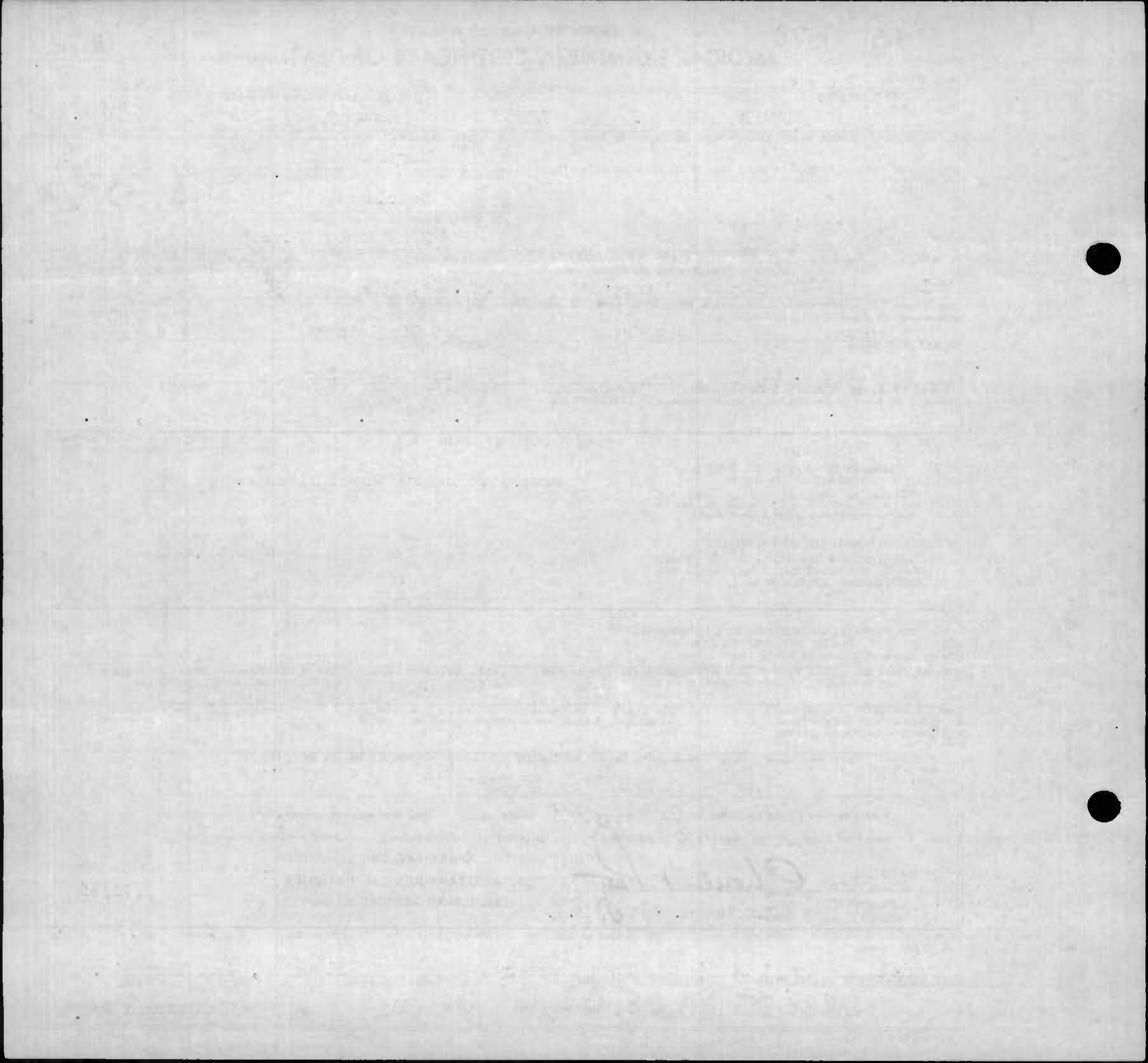
65 0872

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 0872

BIRTH NO.		M.E. CASE NO. 59388		1. NAME OF DECEASED (Type or Print) EDWARD C. LILLY		2. DATE AND HOUR PRONOUNCED DEAD January 23, 1965 4:30 A. M.																											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3909 Pascal Street				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-05 D. STREET ADDRESS (If rural, give location) 3909 Pascal Street																													
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Oct. 28, 1914	9. AGE (In years last birthday) 50	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.																												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Ice Cream		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A																											
13. FATHER'S NAME George E. Lilly				14. MOTHER'S MAIDEN NAME Lizzie Shoemaker																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Carol J. Stemple Pasadena, Md.																													
<table border="1"> <tr> <td rowspan="4" style="writing-mode: vertical-rl; transform: rotate(180deg);">MEDICAL CERTIFICATION</td> <td colspan="6">18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</td> <td rowspan="4">INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr><td colspan="6"></td></tr> <tr><td colspan="6"></td></tr> <tr><td colspan="6"></td></tr> </table>								MEDICAL CERTIFICATION	18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH																		
MEDICAL CERTIFICATION	18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH																										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																											
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																													
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?																													
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Charles S. Petty</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 1/23/65																																	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1 26 65		23C. NAME of CEMETERY or CREMATORY Knob Cemetery		23D. LOCATION (City, town, or county) (State) Pipestem, West Virginia.																											
24A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Mc Cully		ADDRESS 237 Patapsco Ave.																											



BIRTH NO.

65 0873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0873

M.E. CASE NO.

59390

1. NAME OF DECEASED
(Type or Print)

MARY B. COCHRAN

2. DATE AND HOUR PRONOUNCED DEAD

January 23, 1965 8:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

325 E. 30th Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

April 15, 1893

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Dry cleaning

11. BIRTHPLACE (State or foreign country)

Hess, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Cochran

14. MOTHER'S MAIDEN NAME

Hannah Dalton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-22-0469

17. INFORMANT

Mrs. Clara Isenock

ADDRESS

21101

Magnolia, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

If in Baltimore City, give exact location

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/24/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/27/1965

23C. NAME of CEMETERY or CREMATORY

St. Johns

23D. LOCATION

Hyde

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

Charles E. Kurtz Jarrettsville, Md.

ADDRESS

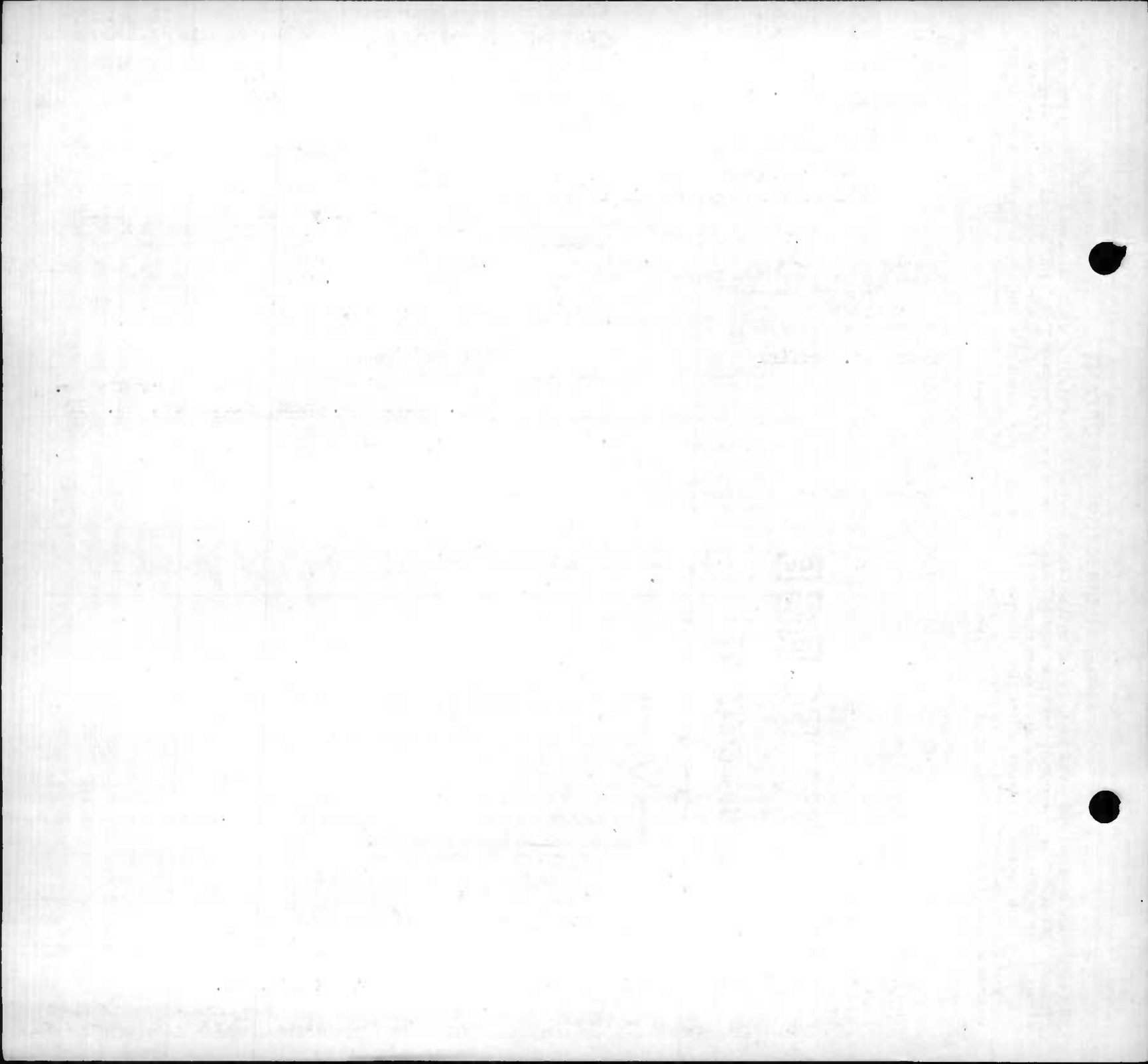
WALLEN
R. L. CO.
BIRMINGHAM

Glenn, J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

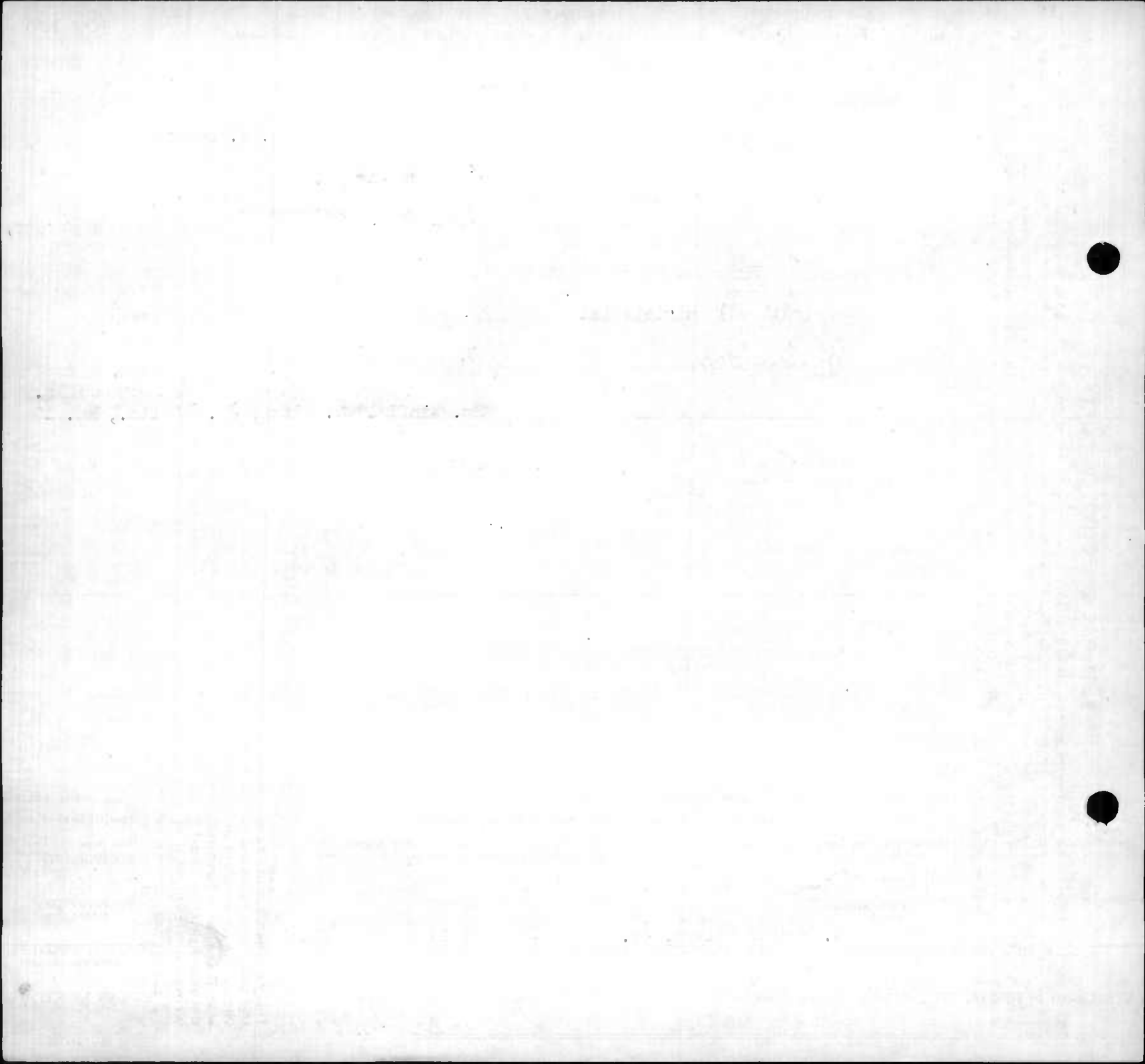
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0874	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 0874</p> <p>M.E. CASE NO.</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> </div>					
<p>1. NAME OF DECEASED (Type or Print) Edna E. Bell</p>			<p>2. DATE AND HOUR OF DEATH January 23, 1965 M.</p>		
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3902 Canterbury Road Baltimore, Maryland 21218</p>			<p>4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 12-01</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore,</p> <p>D. STREET ADDRESS (If rural, give location) 3902 Canterbury Road 21218</p>		
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed</p>	<p>8. DATE OF BIRTH 6/14/1874</p>	<p>9. AGE (In years last birthday) 90</p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker</p>			<p>11. BIRTHPLACE (State or foreign country) New York City, New York</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>
<p>13. FATHER'S NAME George A. Scofield</p>			<p>14. MOTHER'S MAIDEN NAME Martha Cronk</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS Mrs. William A. Hahn 3902 Canterbury Rd. Baltimore, Md. 18</p>	
<p>18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH Congestive Heart Failure</p> <p>INTERVAL BETWEEN ONSET AND DEATH 12-18 hrs</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) Hypertension (B) Arterio-sclerosis (C) Myocarditis</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from May 1943 to Jan 23 1965, that (I) (we) last saw the deceased alive on Jan 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE J. H. Woody</p>				<p>23B. DATE SIGNED 1-26-65</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>				<p>23D. ADDRESS 1403 Park Ave Balti Md</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 1/26/65</p>		<p>24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery</p>	
<p>24D. LOCATION (City, town, or county) (State) Pikesville, Md.</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Wm. J. Vickrey & Sons Baltimore, Md. 21217 North & Pa. Avenues</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

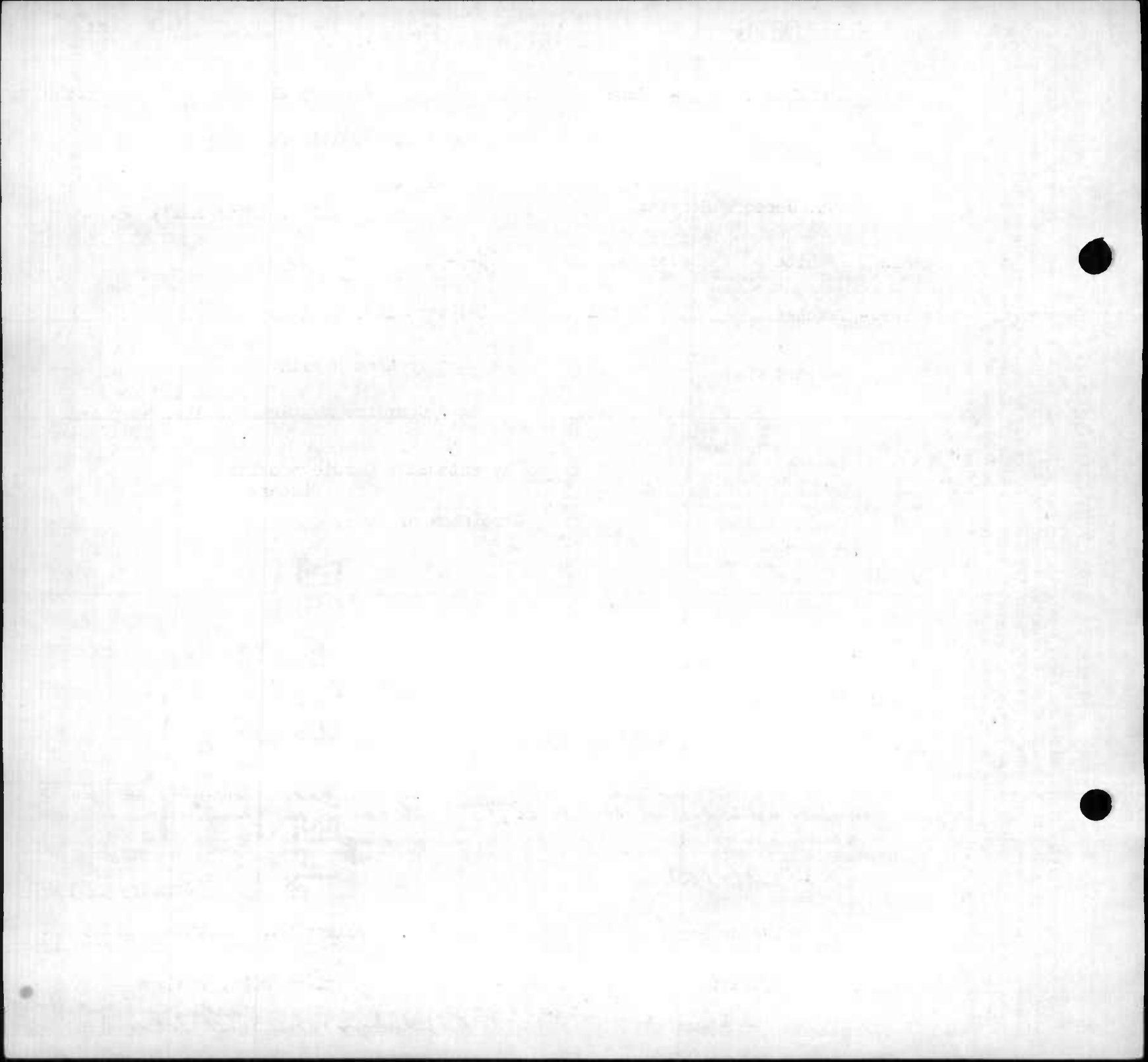
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0875		CERTIFICATE OF DEATH		65 0875	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Levenson Miss Edith Rebecca		2. DATE AND HOUR OF DEATH January - 24 - 1965 5:50 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A. A. County			
FULL NAME OF HOSPITAL OR INSTITUTION Keswick Home 700 West 40th Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis		D. STREET ADDRESS (If rural, give location) 301 Wilson Road	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH Nov-29-1883	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary (retired)		10B. KIND OF BUSINESS OR INDUSTRY Ministerial		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Stephen W. Levenson		14. MOTHER'S MAIDEN NAME Fannie H. Moore		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Winfield S. Ditch, Jr.	
18. 3320 X I		CAUSE OF DEATH		ADDRESS 4 Longwood Rd., Balto., Md. 10	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Bilateral bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cerebral thrombosis with left hemiparesis		1 month	
		(C) Cerebral atherosclerosis			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Atherosclerotic Heart Disease	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 1-24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Hunter Wilson, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-24-65	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr.		23D. ADDRESS Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/1965		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons		ADDRESS Baltimore, Md. 21217 North & Pa. Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0876				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0876	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Barkalow, Louise Jane				January 22 1965 5.10P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
St. Josephs Hospital				Maryland Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baldwin 53-00			
D. STREET ADDRESS (If rural, give location)				Strawberry Hill, Baldwin Mill, Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?		
Female	White	Never Married	5-5-94	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired- Teacher		School		Indianapolis, Indiana			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
2.				Hester Anne Hereth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						Sweet Air Road	
						Rev. Converse Hunter Phoenix, Maryland	
18. 443XX 175.0				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Hypertensive Cardiovascular Disease			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(B) Carcinoma of Ovary			
ANTECEDENT CAUSES				(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 22 19 65 to January 22 19 65, that (I) (we) last saw the deceased alive on January 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Salvador Marse						January 22 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D. 1400 N. Caroline St. Baltimore 21213 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		2/1/1965		Crown Hill Cemetery		Indianapolis, Indiana	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 26 1965		Robert E. Farley M.D.		Wm. J. Vicknair & Sons		Baltimore, Md. 17 North & Penn. Avenues	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0877	
BIRTH NO. 65 0877		CERTIFICATE OF DEATH		X	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rev. Walter C. CRAFT		January 23, 1965 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
St. Joseph Hospital		Virginia		1-43	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Chatham			
		D. STREET ADDRESS (If rural, give location)		Visiting- Balto. 826 Central Ave	
Rt. 3 Box 208					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Col.	Married	8-31-79	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Minister & Farmer				Chatham Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES CRAFT				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT daughter ADDRESS	
NO				Mrs. Molinda Jett 826 Central Avenue	
18. 331X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Cerebral hemorrhage, right			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 12th 1965 to January 23, 1965, that (I) (we) last saw the deceased alive on January 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Melencio Ventura				Jan. 24, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Melencio Ventura		M.D. 1400 N. Caroline Street Baltimore 13, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
REMOVAL	1/25/65	CHATHAM, REM.		CHATHAM, VA.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1965		Robert E. Taylor, M.D.		COOKE & MINNIS CHATHAM, VA.	

James Craft

No.

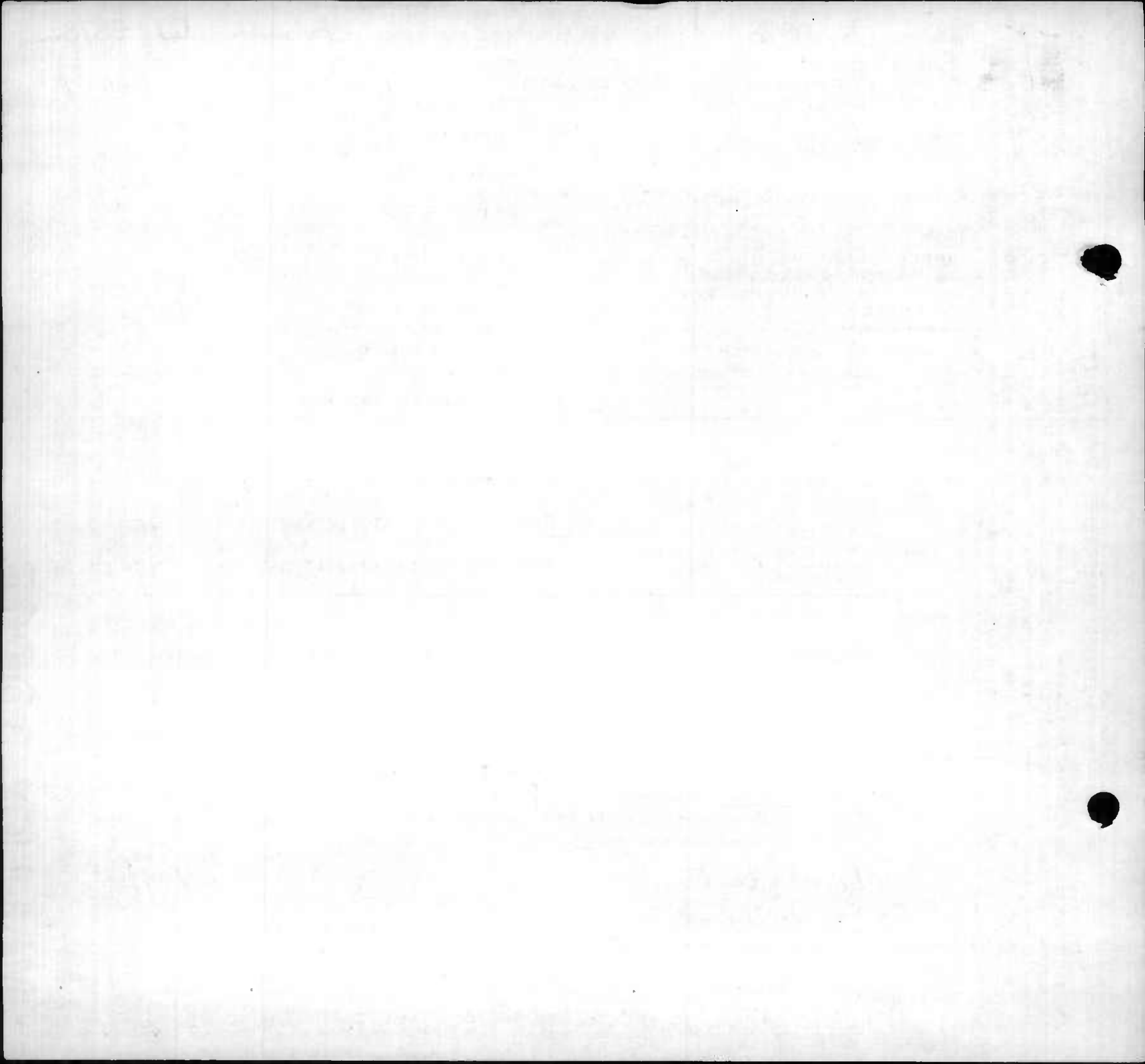
Removal of the CHAIRMAN, 1880. 1/2

Book of the CHAIRMAN, 1880. 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0878		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0878	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) RUFENACHT, STANLEY HOWARD			
2. DATE AND HOUR OF DEATH 1/24/65 1:00 P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN ARM 53-00 D. STREET ADDRESS (If rural, give location) Box 530			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/13/04	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER			10B. KIND OF BUSINESS OR INDUSTRY BOX MAKING INDUSTRY		11. BIRTHPLACE (State or foreign country) SWITZERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HERMAN RUFENACHT				14. MOTHER'S MAIDEN NAME SOPHIE PEARCE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN No		16. SOCIAL SECURITY NO. 216-01-1772		17. INFORMANT HOSPITAL RECORDS		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 332X1 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) RECURRENT CEREBRAL THROMBOSES DUE TO COMPLICATED BY MAJOR MOTOR SEIZURES (B) GENERALIZED ARTERIOSCLEROSIS DUE TO AND (C) HYPERTENSIVE ENCEPHALOPATHY		INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS YEARS	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/23 1965 to 1/24 1965, that (I) (we) last saw the deceased alive on 1/24 1965 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William R. Linton, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/24/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1965		24C. NAME OF CEMETERY or CREMATORY Mt. Christian Cemetery		24D. LOCATION (City, town, or county) (State) Harford Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Lassala Funeral Home		ADDRESS (36) 7401 Belair Road	



1
M. 235

61-30757
65 0879

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0879

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BELINDA M. McDONALD

2. DATE AND HOUR PRONOUNCED DEAD

January 21, 1965 11:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

124 E. Cross Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

124 E. Cross Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED ☒ WIDOWED, DIVORCED (Specify)

--

8. DATE OF BIRTH

Oct. 20, 1961

9. AGE (In years last birthday)

3

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lester L. McDonald

14. MOTHER'S MAIDEN NAME

Mary A. Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

-

17. INFORMANT

ADDRESS

Mrs. Mary McDonald 124 E. Cross St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial Pneumonitis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1/21/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/26/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

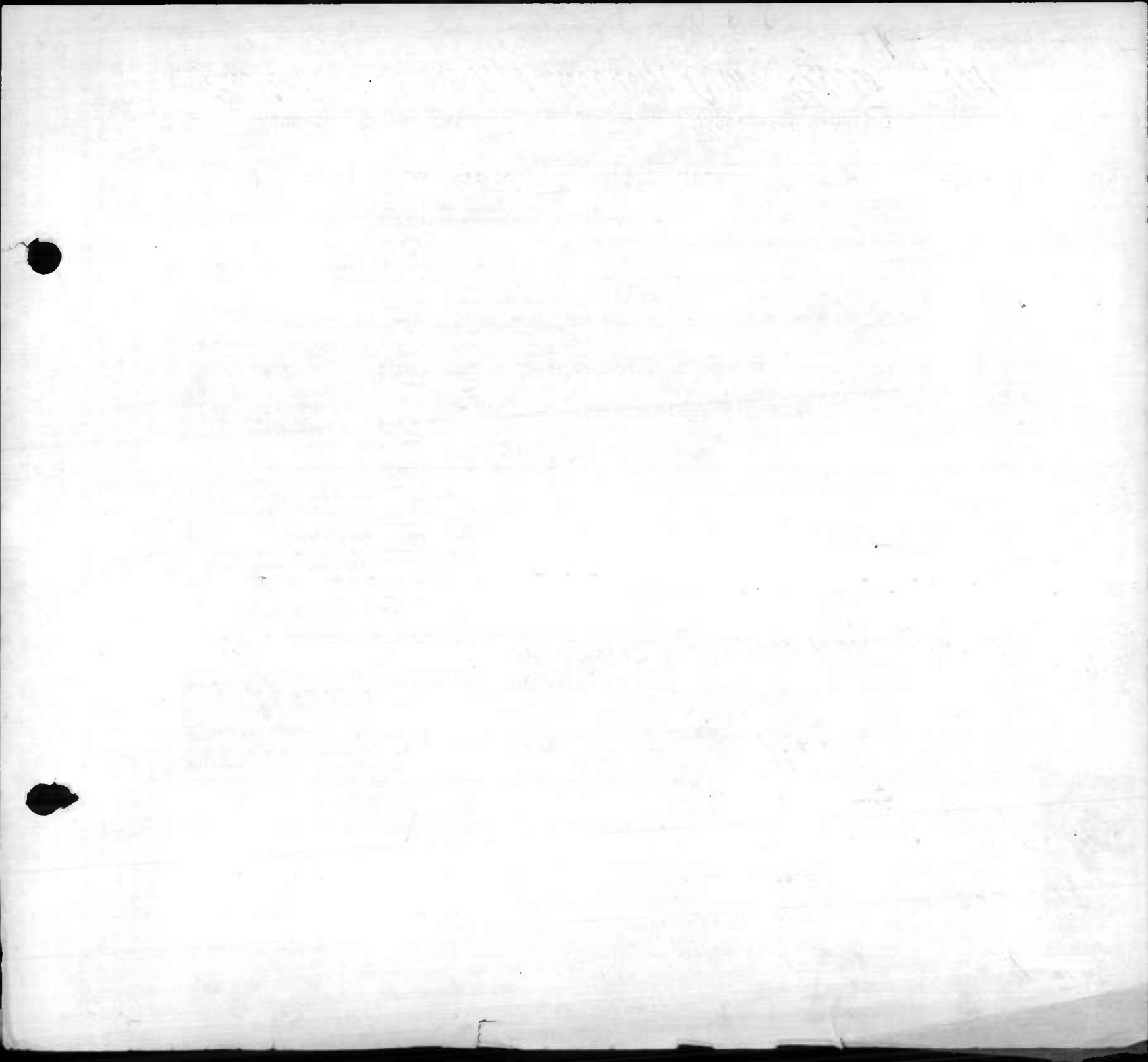
JOHN F. DENNY, INC. 715 Light St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0880		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0880	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JAMES NORRINGTON		2. DATE AND HOUR OF DEATH 1/22/65 9:01 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY X		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 18-01	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		6. STREET ADDRESS (If rural, give location) 204 N. FREMONT AVE. Apt. 8			
5. SEX M	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/17/1889	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Doctor		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Ga.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-3307		17. INFORMANT Annie Mae Norrington	
18. 163X I		CAUSE OF DEATH		ADDRESS 204 N. Fremont Ave	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)		(A) CARCINOMA OF LUNG DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Eugene Mott		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan. 22, 1965	
23C. PHYSICIAN'S NAME (Type) Kenneth Eugene Mott		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/1965		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balt. Md.	
24D. LOCATION (City, town or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. School St.			

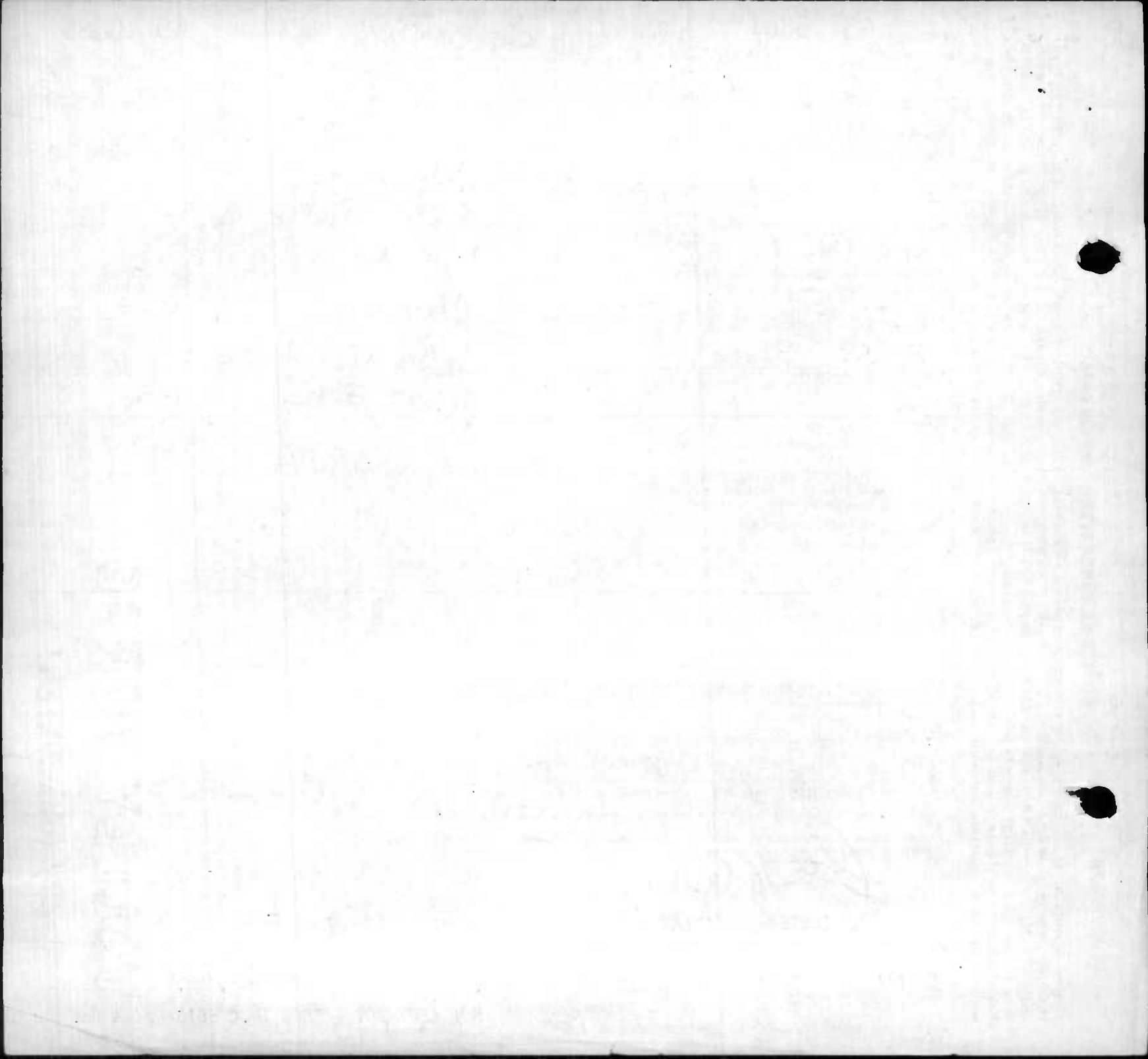


B-2601

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0881	
BIRTH NO. 65 0881		M.E. CASE NO. RANDALL		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Gary A. Baker		2. DATE AND HOUR OF DEATH Jan 23, 1965 2:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Balt., Inc		A. STATE B. COUNTY Maryland, Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5710 Rockspring Rd			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH Oct 6, 1964	9. AGE (In years last birthday) 3 17	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Baker		14. MOTHER'S MAIDEN NAME Ricki Schwartz		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Robert Baker ADDRESS Same	
18. 7620 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Massive Aspiration DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 6, 1964 to Jan 23, 1965, that (I) (we) lost saw the deceased alive on Jan 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester H. Caplan		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan 23, 1965	
23C. PHYSICIAN'S NAME (Type) LESTER CAPLAN		23D. ADDRESS M.D. 1401 Reisterstown Rd. Balt. & Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/65		24C. NAME OF CEMETERY or CREMATORY Beth Tillech Cong.	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1965		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR SOL LEVINSON & BROS INC 6010 Reist Rd.		24H. ADDRESS		24I. SIGNATURE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 0882

BIRTH NO. 65 0882

M.E. CASE NO. 593K3

1. NAME OF DECEASED
(Type or Print)

NAIDITCH, PHILIP

2. DATE AND HOUR OF DEATH

1/22/65

9²⁰/p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

SINAI HOSPITAL OF BALTO, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

15-11

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3308 EGERTON RD. #15

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12/15/97

9. AGE (In years last birthday)

67

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MERCHANT

10B. KIND OF BUSINESS OR INDUSTRY

GROCERY STORE

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Abraham NAIDITCH

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Chart (hospital)

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
M.D. [Signature]
CHIEF OF BASSIST MEDICAL EXAMINER

CAUSE OF DEATH

A. ACUTE MYOCARDIAL INFARCTION

19. DATE OF OPERATION

420.1 - E904.3

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

19A. DATE OF OPERATION

1/22/65

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

19A. DATE OF OPERATION

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

1 17 65

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

STREET (? PLACE)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☒

21C. WHERE DID INJURY OCCUR?

UNKNOWN

21F. HOW DID INJURY OCCUR?

PATIENT FELL

22. I certify that (this hospital) attended the deceased from 20 JANUARY 19 65 to 22 JANUARY 19 65, that (we) last saw the deceased alive on 22 JANUARY 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

Barry M. Cohen, M.D.

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/22/65

23C. PHYSICIAN'S NAME (Type)

BARRY M. COHEN

M.D.

23D. ADDRESS

SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/24/65

24C. NAME OF CEMETERY OR CREMATORY

WORKMENS CIRCLE

24D. LOCATION

BALTIMORE

(City, town, or county)

(State)

MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

10 JAN 26 1965

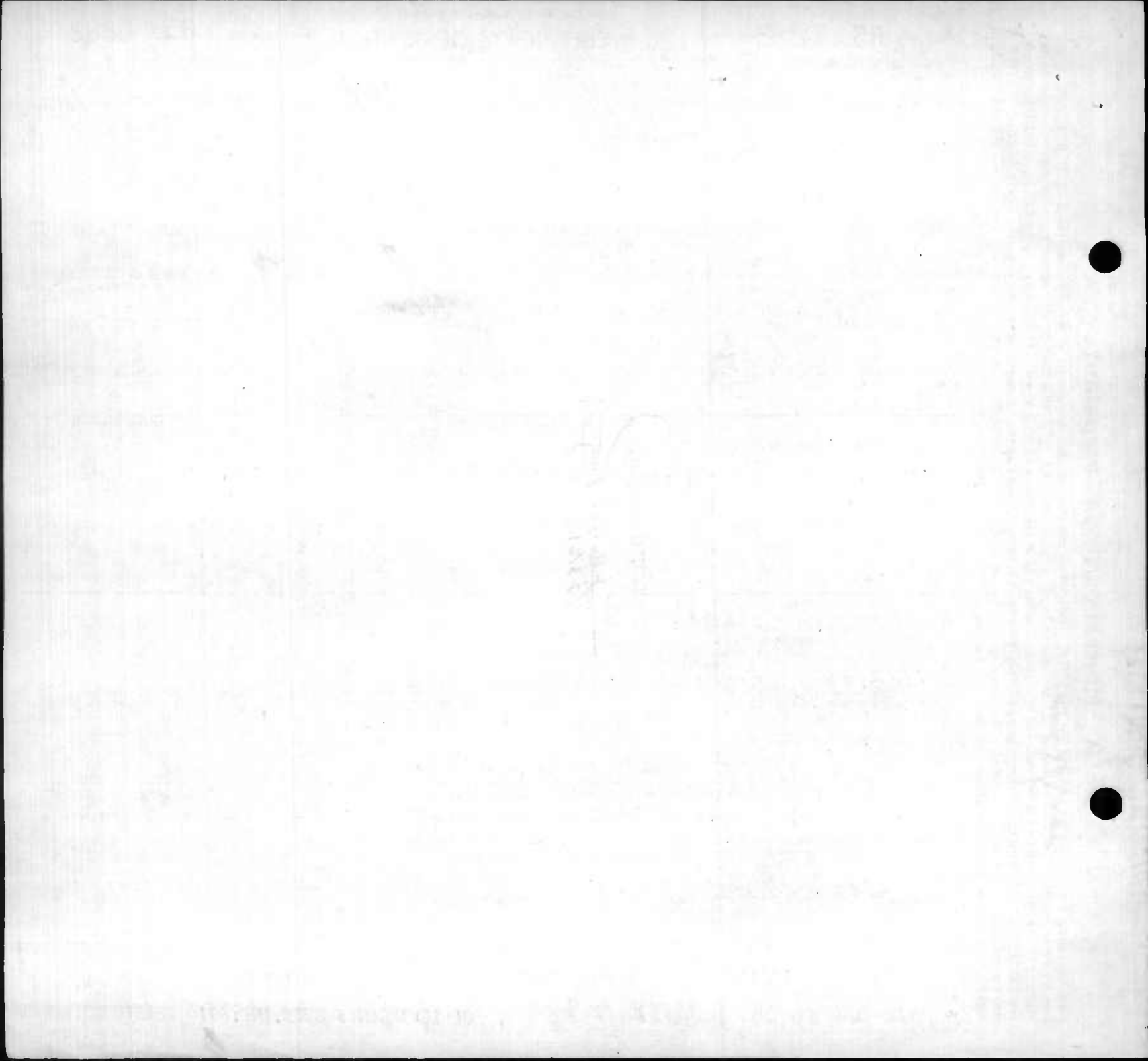
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

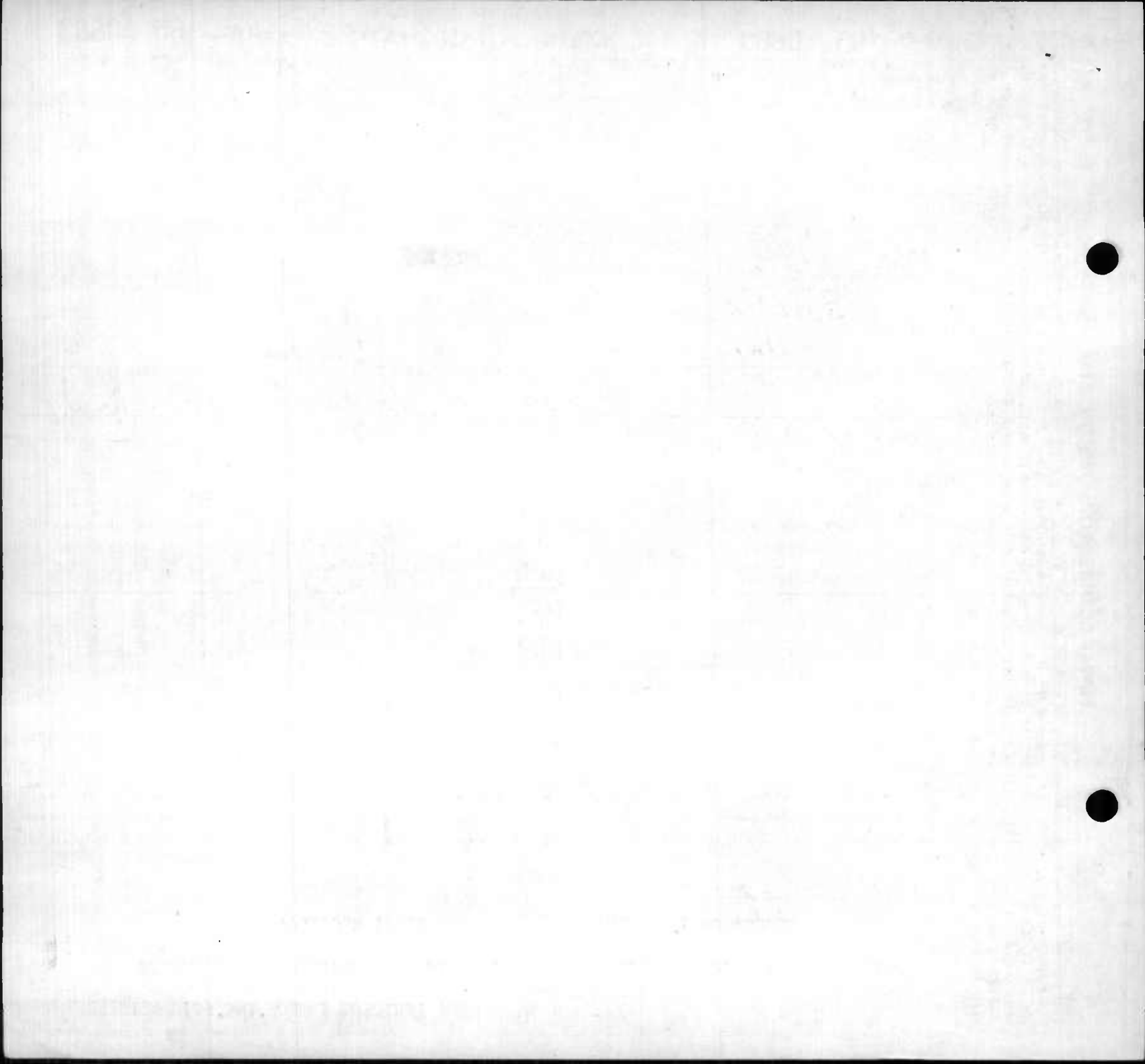
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 0883</u>				
BIRTH NO. <u>65 0883</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Nathan Zeiger</u>					2. DATE AND HOUR OF DEATH <u>1-25-65 1:15 AM</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Balto</u>					A. STATE <u>Md.</u>				
					B. COUNTY <u>27-20</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #15</u>				
					D. STREET ADDRESS (If rural, give location) <u>3206 Glen Ave.</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>82</u>	9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>SELF-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>218-32-0797</u>		17. INFORMANT <u>Mrs. Sylvia Schneider</u>			ADDRESS <u>3206 Glen Ave</u>	
18. <u>177X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Gen. Carcinomatosis secto</u> DUE TO <u>Carcinoma of Prostate</u> DUE TO <u>Pyelonephritis, severe</u> DUE TO <u>Pneumonia ?</u>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>64</u> to <u>1-25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Venerando J. Maximo</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1-25-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>VENERANDO J. MAXIMO</u> M.D.					23D. ADDRESS <u>SINAI HSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/26/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARRINGTON)</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>			25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u> ADDRESS <u>6010 REISTERSTOWN</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 65 0884

BIRTH NO. 65 0884

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Henry Earl Sacks

2. DATE AND HOUR OF DEATH

1-23-65 9:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3821 Cottage Ave.
Baltimore #15, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3821 COTTAGE AVENUE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2/1/1910

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY

USED CARS

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HERMAN SACKS

14. MOTHER'S MAIDEN NAME

LENA LIPSITZ

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-30-7273

17. INFORMANT

ADDRESS

MRS. ADA SACKS 3821 COTTAGE AVENUE

18.

4:20 PM 260X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Ventricular Fibrillation

INTERVAL BETWEEN
ONSET AND DEATH

minutes

(B) DUE TO

Arteriosclerotic Heart Disease 3 years

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

Years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED
While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from December 1964 to Jan 1965, that (1) (we) last saw the deceased alive on December 27, 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David I. Miller

M.D.

Attending Phys. ☒

Med. Director ☐

Stoll Phys. ☐

23B. DATE SIGNED

1-23-65

23C. PHYSICIAN'S NAME (Type)

David I. Miller

M.D.

23D. ADDRESS

Linson Rd. Owings Mills, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/25/65

24C. NAME OF CEMETERY or CREMATORY

HEBREW YOUNG MEN

24D. LOCATION (City, town, or county) (State)

BALTIMORE

MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

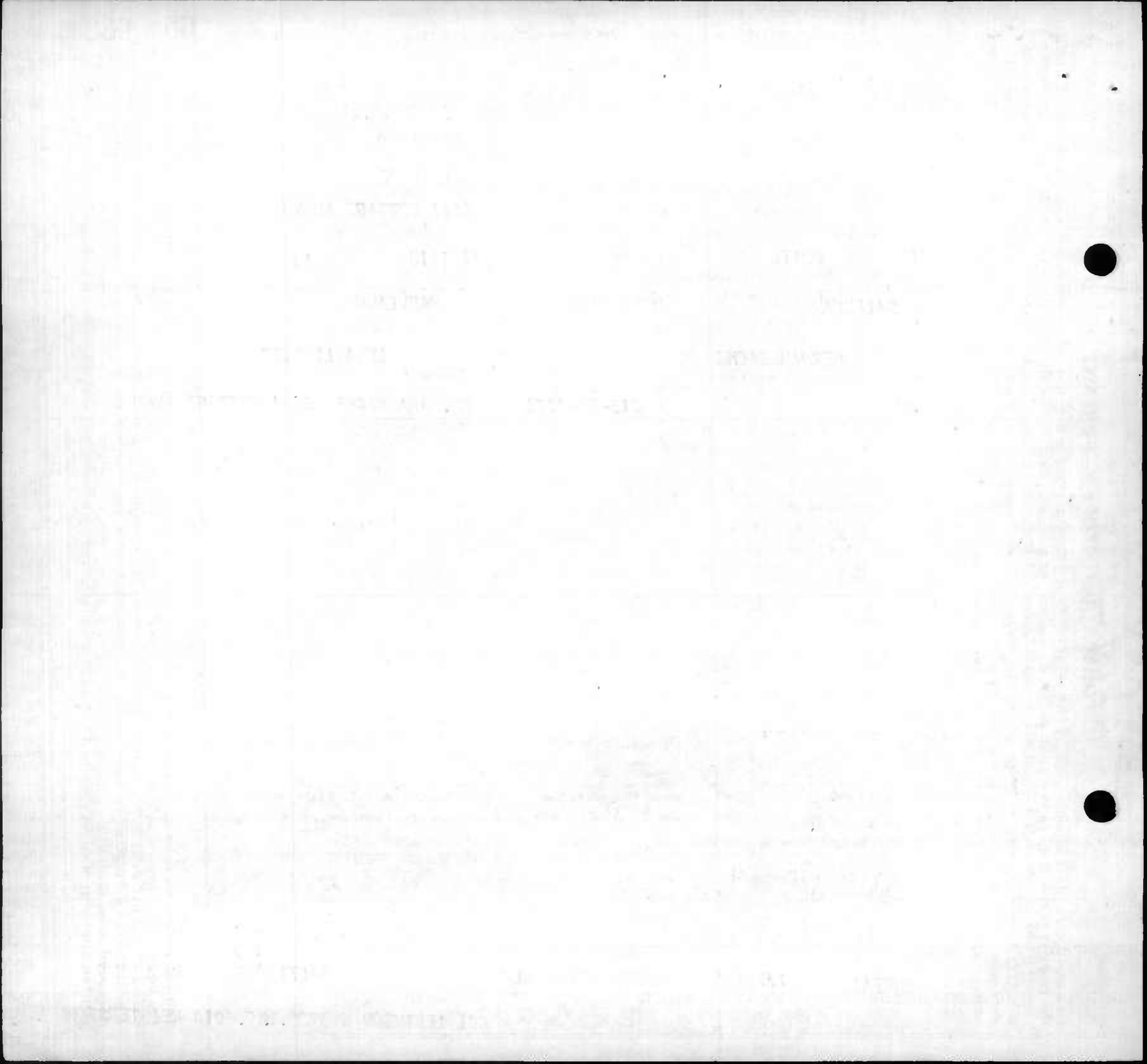
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

ADDRESS

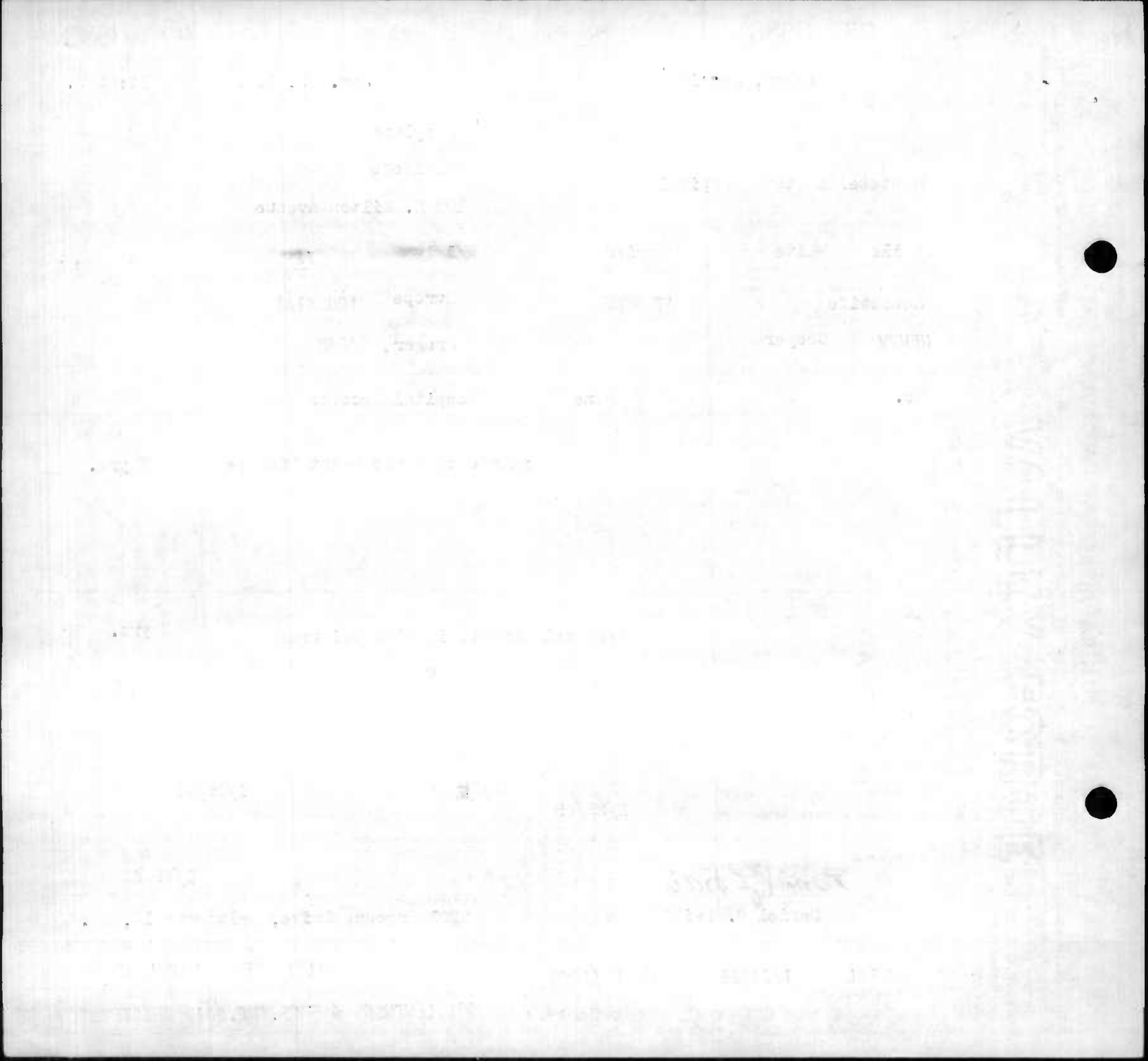


BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0885			
BIRTH NO. 65 0885				M.E. CASE NO. 59402			
1. NAME OF DECEASED (Type or Print) DAVID HARRY LUSTMAN				2. DATE AND HOUR PRONOUNCED DEAD 1-24-65 8:10 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL - DOA				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland Baltimore 27-17 5103 Chalgrove Avenue - 21215			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 10/16/1909	
9. AGE (In years last birthday) 55		10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL GROCERY				10B. KIND OF BUSINESS OR INDUSTRY PROPRIETOR			
13. FATHER'S NAME GERSHON LUSTMAN				14. MOTHER'S MAIDEN NAME IDA RICHTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-09-2474		17. INFORMANT ADDRESS MRS. MIREL LUSTMAN 5103 CHALGROVE AVE	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) Hypertensive arteriosclerotic cardiovascular disease with coronary thrombosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.				CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 1-25-65			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 1/27/65		23C. NAME of CEMETERY or CREMATORY SHAAREI ZION		23D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

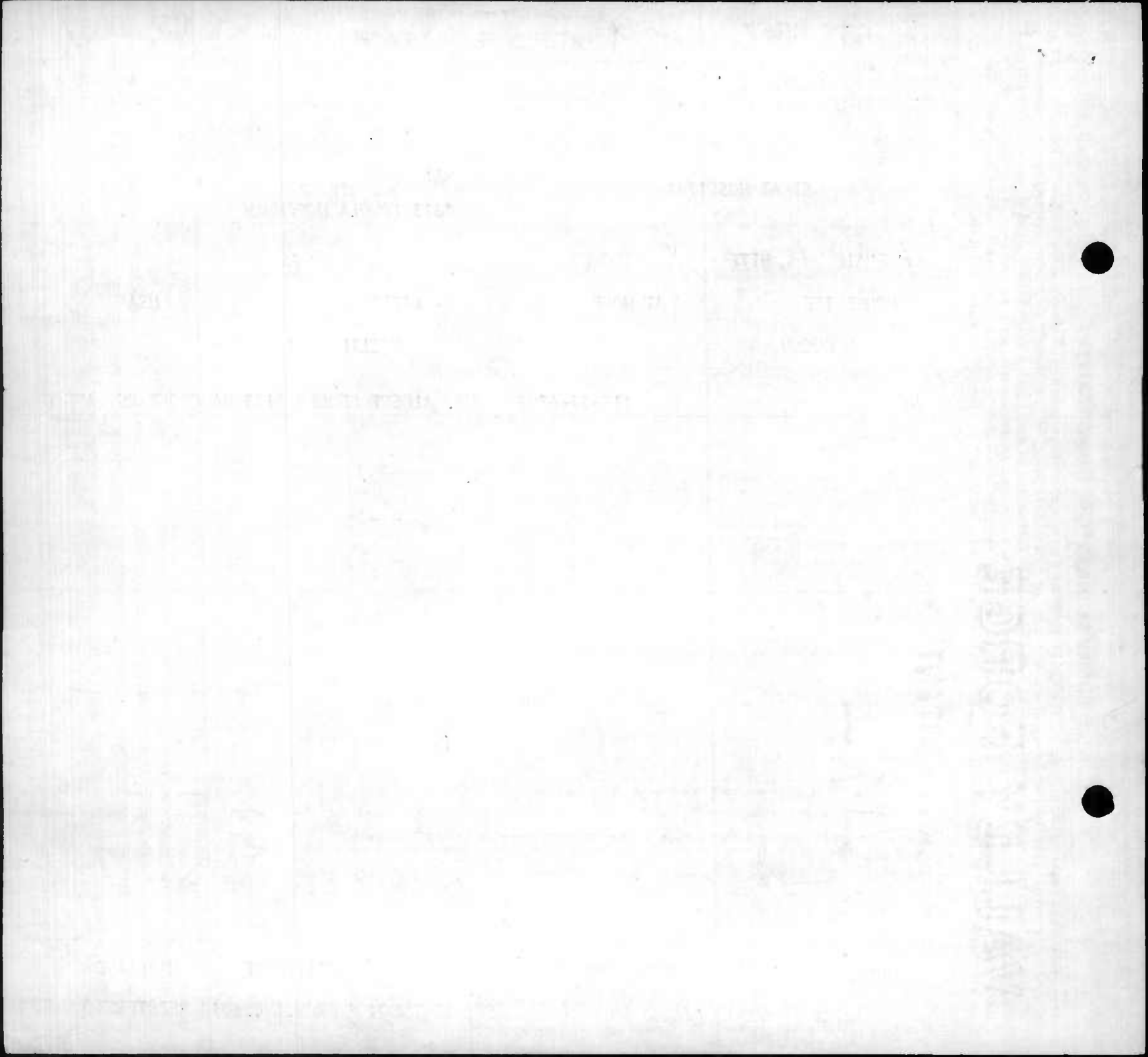
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0886	
BIRTH NO. 65 0886		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Becker, Jennie		2. DATE AND HOUR OF DEATH Jan. 25, 1965 10:05 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 102 N. Milton Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH	9. AGE (In years) 78	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Europe (RUSSIA)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY Cooper			14. MOTHER'S MAIDEN NAME Kruger, SARAH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		ADDRESS	
18. 4-20-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (C) DUE TO				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 7 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral thrombosis with seizures				2 yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/25/64 19 to 1/25/65 19, that (I) (we) last saw the deceased alive on 1/25/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Daniel G. Lai				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) Daniel G. Lai				23D. ADDRESS M.D. 2201 Argonne Drive, Baltimore 18, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/26/65		24C. NAME OF CEMETERY or CREMATORY BNAI JACOB		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 0887					CERTIFICATE OF DEATH			Registered No. 65 0887		
1. NAME OF DECEASED (Type or Print) <i>Rose Gerber</i>					2. DATE AND HOUR OF DEATH <i>Jan 22, 1965 9:00 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2613 LOYOLA NORTHWAY					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 76	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LATVIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME MOLLIE ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-34-6799		17. INFORMANT ADDRESS MR. ALBERT GERBER 3113 BANCROFT RD APT D					
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis C.V.D.					CAUSE OF DEATH (A) Cerebral Infarction due to Cerebral Arteriosclerosis (B) 48 hrs. (C) to					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 22 9:00 AM 1965 to Jan 22 1965 , that (I) (we) last saw the deceased alive on Jan 22 9:00 AM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
22A. SIGNATURE <i>Albert E. Taylor, M.D.</i>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			22B. DATE SIGNED Jan 22, 1965		
23C. PHYSICIAN'S NAME (Type) Albert E. Taylor					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/65		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW			24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD				

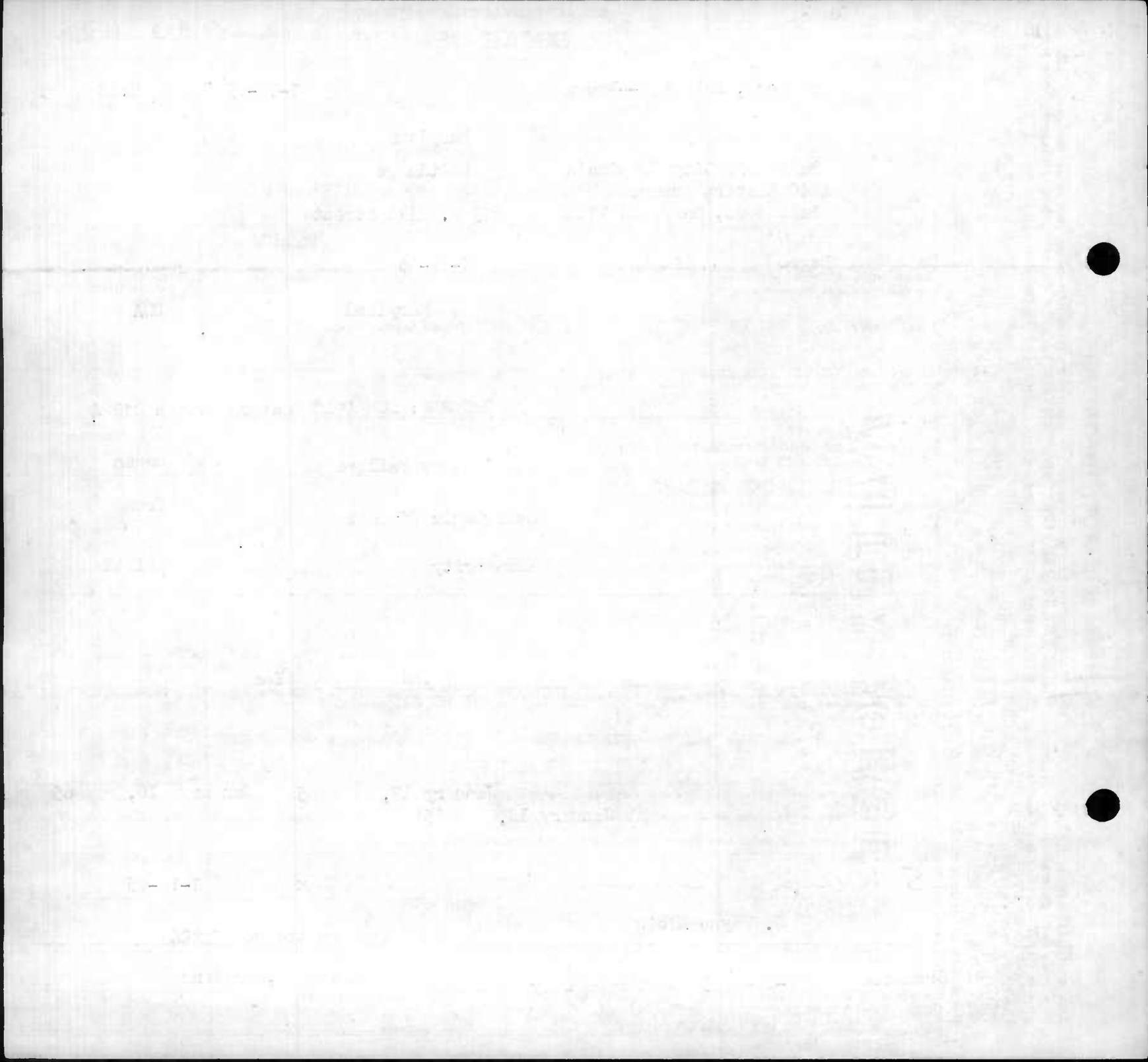


cdg: 426316

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0888	
BIRTH NO. 65 0888		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Drummond, Baby Boy-- Laura			
2. DATE AND HOUR OF DEATH		1-18-65 8:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
Baltimore City Hospitals		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
4940 Eastern Avenue		D. STREET ADDRESS (If rural, give location) 113 W. Hill Street			
Baltimore, Maryland 21224					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1-17-65	9. AGE (In years last birthday) 1	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Respiratory Failure		Began	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hemorrhagic Disease		from	
		(C) Immaturity		birth	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from January 17, 19 65 to January 18, 19 65, that (I) (we) last saw the deceased alive on January 18, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE S. Wayne Klein M.D.		23B. DATE SIGNED 1-18-65	
23C. PHYSICIAN'S NAME (Type) S. Wayne Klein		23D. ADDRESS 4940 Eastern Avenue 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 1-20-1965		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0889</u>	
BIRTH NO. <u>65 0889</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Herbert Newell Gerry</u>				January 24, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2300 Garrison Blvd.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>15-48</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>2300 Garrison Blvd.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 16, 1871</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance -</u>			11. BIRTHPLACE (State or foreign country) <u>Port Deposit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lucius A.C. Gerry</u>			14. MOTHER'S MAIDEN NAME <u>Jane A. Vanneman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>J. L. Gerry 4306 Ridgewood Avenue</u>
18. <u>450.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonitis, Viral</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arterio</u> <u>Sclerosis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Serum</u> INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 14th 1965</u> to <u>Jan 24th 1965</u> , that (I) (we) last saw the deceased alive on <u>Jan 24th 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Paul Byerly</u>				23B. DATE SIGNED <u>1/26/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Paul Byerly</u>				23D. ADDRESS <u>5620 York Rd Balto 12 MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>	
				ADDRESS <u>4600 Liberty Heights</u>	

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BIRTH NO. 65 0890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO. 59399

1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
LAURA WALKER				1-24-65 12:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
924 WATSON STREET - DOA				B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 3-02			
				D. STREET ADDRESS (If rural, give location) 924 Watson Street - 21202			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Female	Colored	Married	Nov. 10, 1905	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				Simon Walker 924 Watson Street			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
PETER W. RIECKERT, M.D.				ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		1/29/65		Balto National Cemetery		Balto., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
JAN 26 1965		Robert E. Farkner		A. Halstead		918 Druid Hill Ave.	

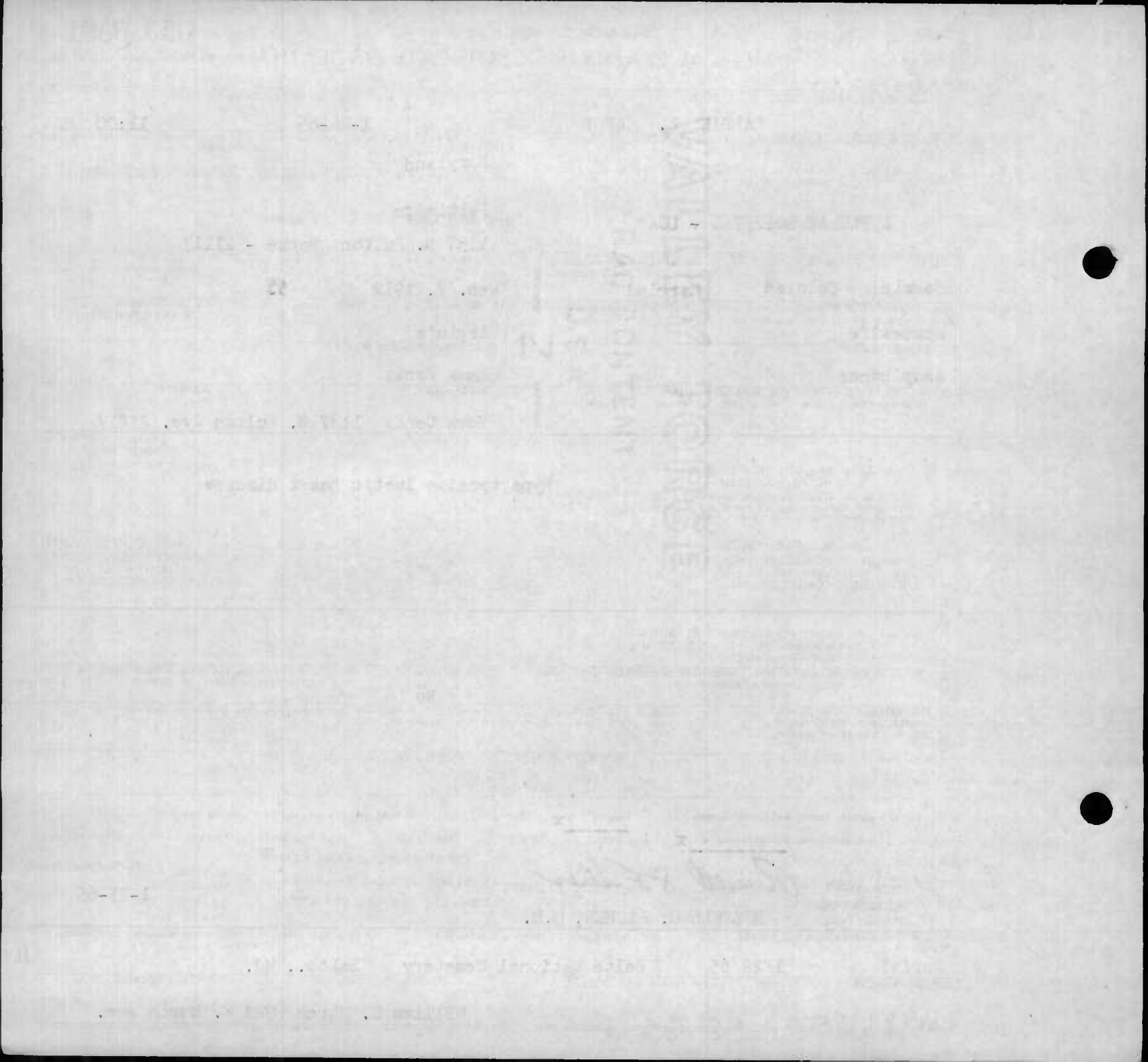
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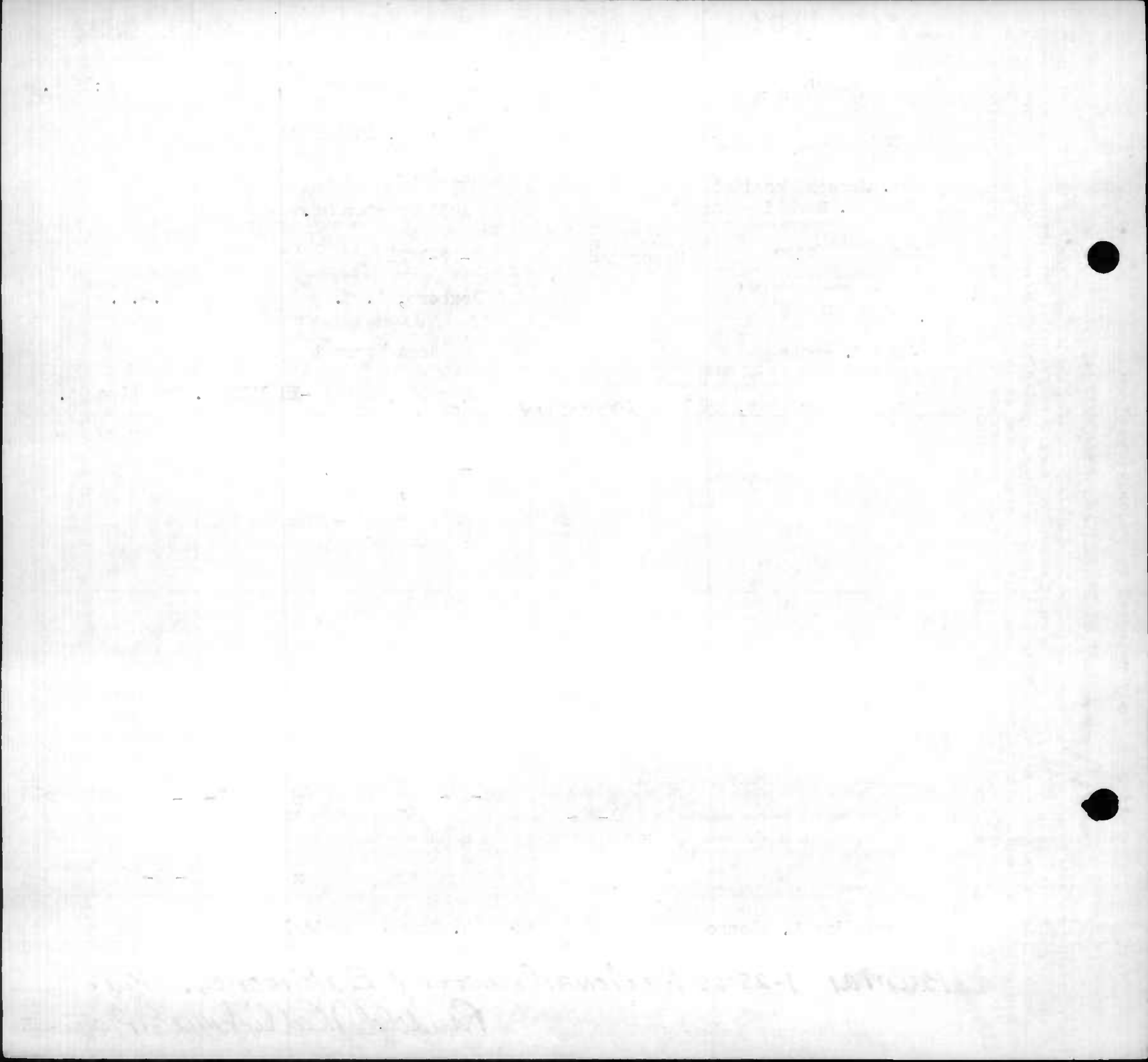
BIRTH NO. 65 0891		BALTIMORE CITY HEALTH DEPARTMENT		65 0891	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____					
1. NAME OF DECEASED (Type or Print) CARRIE L. CANDY			2. DATE AND HOUR PRONOUNCED DEAD 1-24-65 11:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD LUTHERAN HOSPITAL - DOA			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 16-03 D. STREET ADDRESS (If rural, give location) 1137 N. Fulton Avenue - 21217		
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 2, 1912	9. AGE (In years last birthday) 52	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Andy Banks			14. MOTHER'S MAIDEN NAME Emma Banks		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS York Candy 1137 N. Fulton Ave. 21217		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive luetic heart disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/28/65	23C. NAME of CEMETERY or CREMATORY Balto National Cemetery		23D. LOCATION (City, town, or county) (State) Balto., Md.
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS William C. March 928 E. North Ave.		



FUNERAL DIRECTOR: IMPORTANT

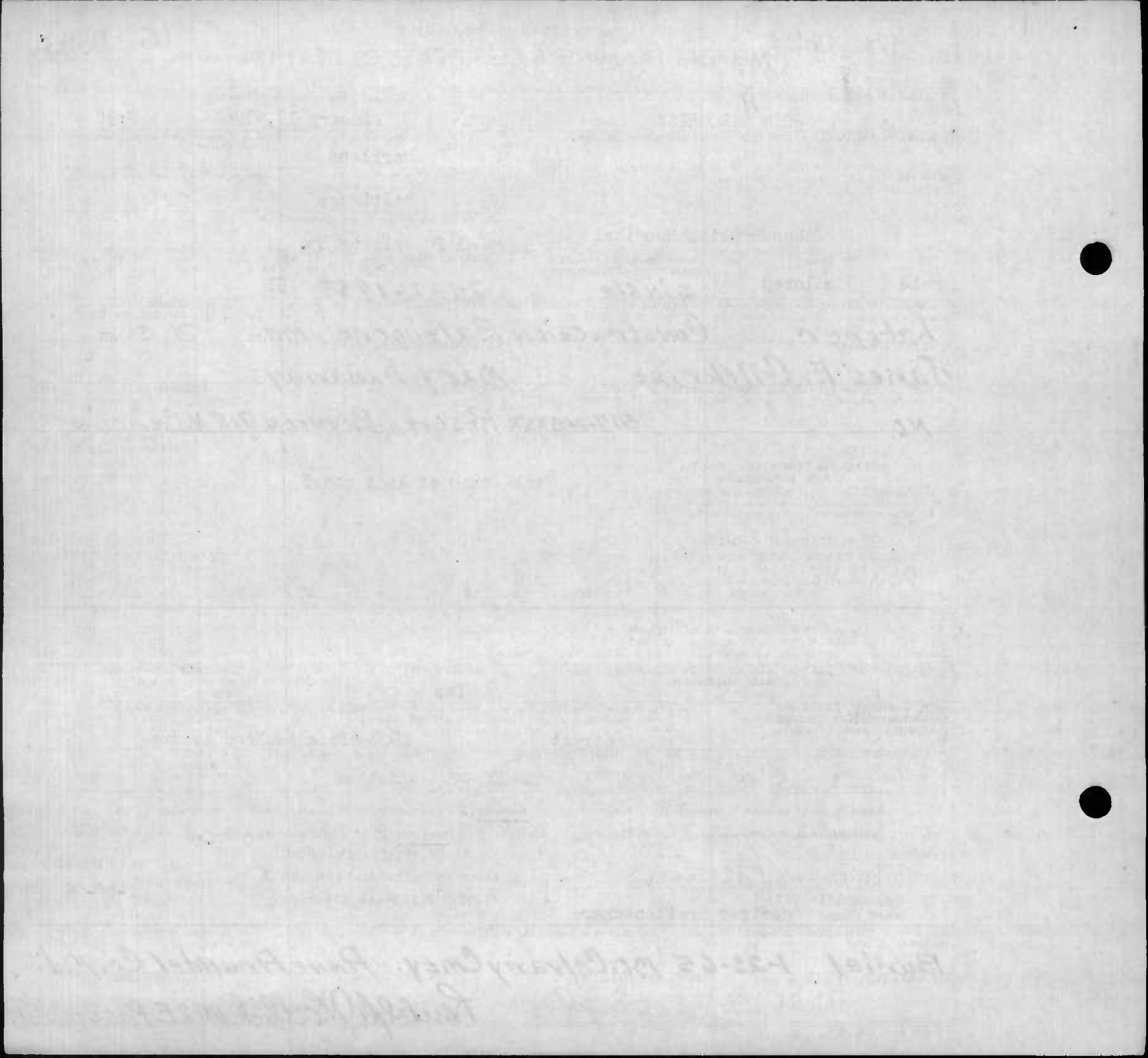
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0892	
BIRTH NO. 65 0892		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John H. Jones		2. DATE AND HOUR OF DEATH January 20, 1965 5:25 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital 1400 N. Caroline Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, BALTIMORE B. COUNTY 8-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1631 Preston St. / EAST			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Seperated	8. DATE OF BIRTH 5-18-1924	9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) On Pension		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Roxboro, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Jones				14. MOTHER'S MAIDEN NAME Rosa Barnett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes October, 1943		16. SOCIAL SECURITY NO. 218-14-5814		17. INFORMANT Marcella Dunlap - (sister)		ADDRESS 1720 N. Caroline St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Cerebro-vascular accident DUE TO hemorrhage, right massive		INTERVAL BETWEEN ONSET AND DEATH	
(B) Hypertensive cardio-vascular DUE TO disease				(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-19-65 to 1-20-65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-20-65 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE Bernardino A. Alonso				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-65	
23C. PHYSICIAN'S NAME (Type) Bernardino A. Alonso				23D. ADDRESS M.D. St. Joseph Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65		24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 1412 E. Preston St.	



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G-426

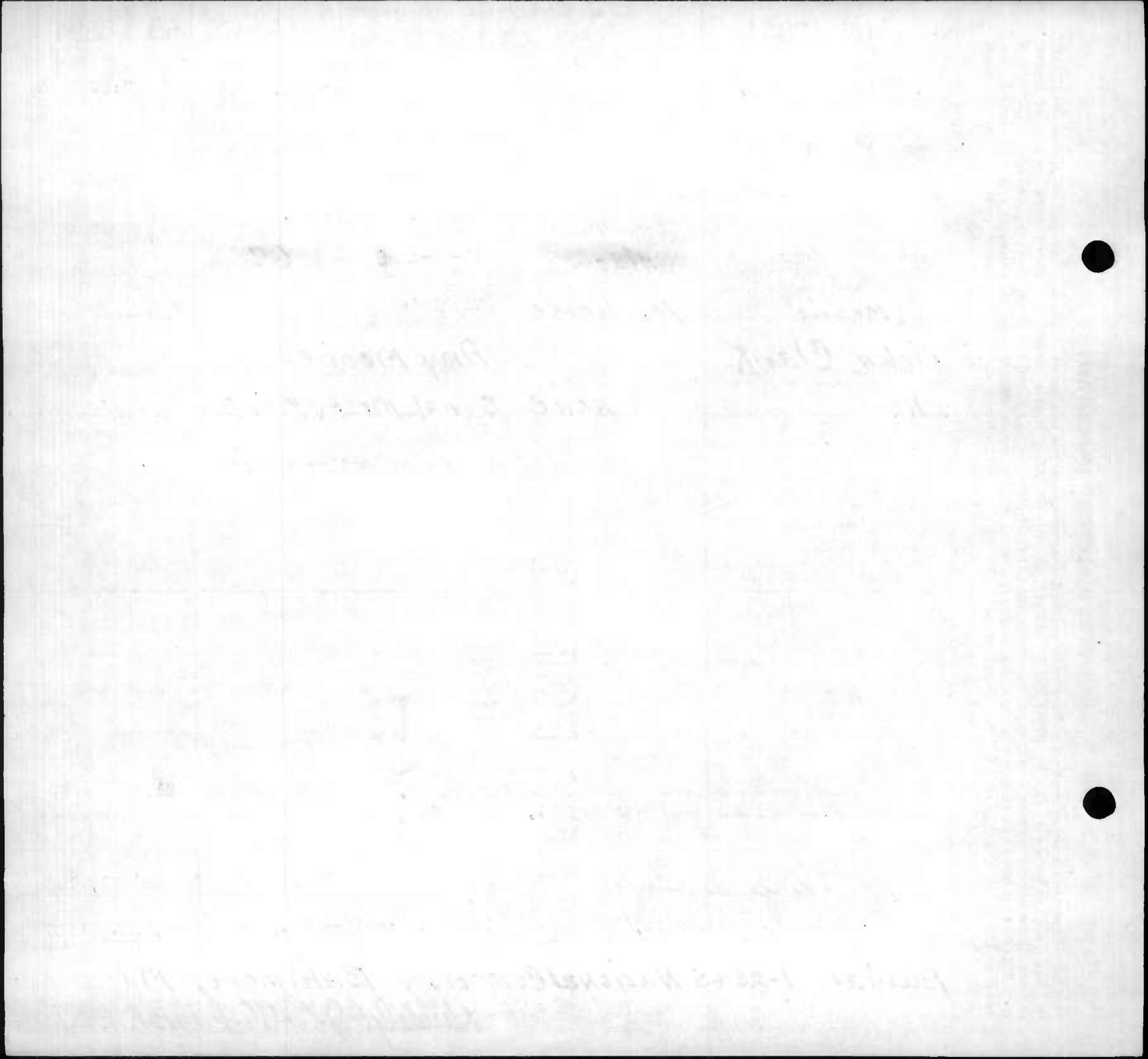
BALTIMORE CITY HEALTH DEPARTMENT				65 0893			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. 65 0893			
1. NAME OF DECEASED (Type or Print) JOHN GILCHRIST				2. DATE AND HOUR PRONOUNCED DEAD January 19, 1965 9:38 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1120 Orleans St.			
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 2-22-1933	9. AGE (In years last birthday) 31	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Gilchrist			14. MOTHER'S MAIDEN NAME Mary Dunaway				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 21724-5858		17. INFORMANT Rosetta Boynton ADDRESS 918 N. Caroline St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (A) Stab wound of left chest DUE TO (B) _____ DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1500 Block Ashland Avenue			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 19 65 ?	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Stabbed				
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breiteneker M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breiteneker ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-20-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-23-65		23C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cmet.		23D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
24A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Randolph J. Collick ADDRESS 142 E. Preston St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

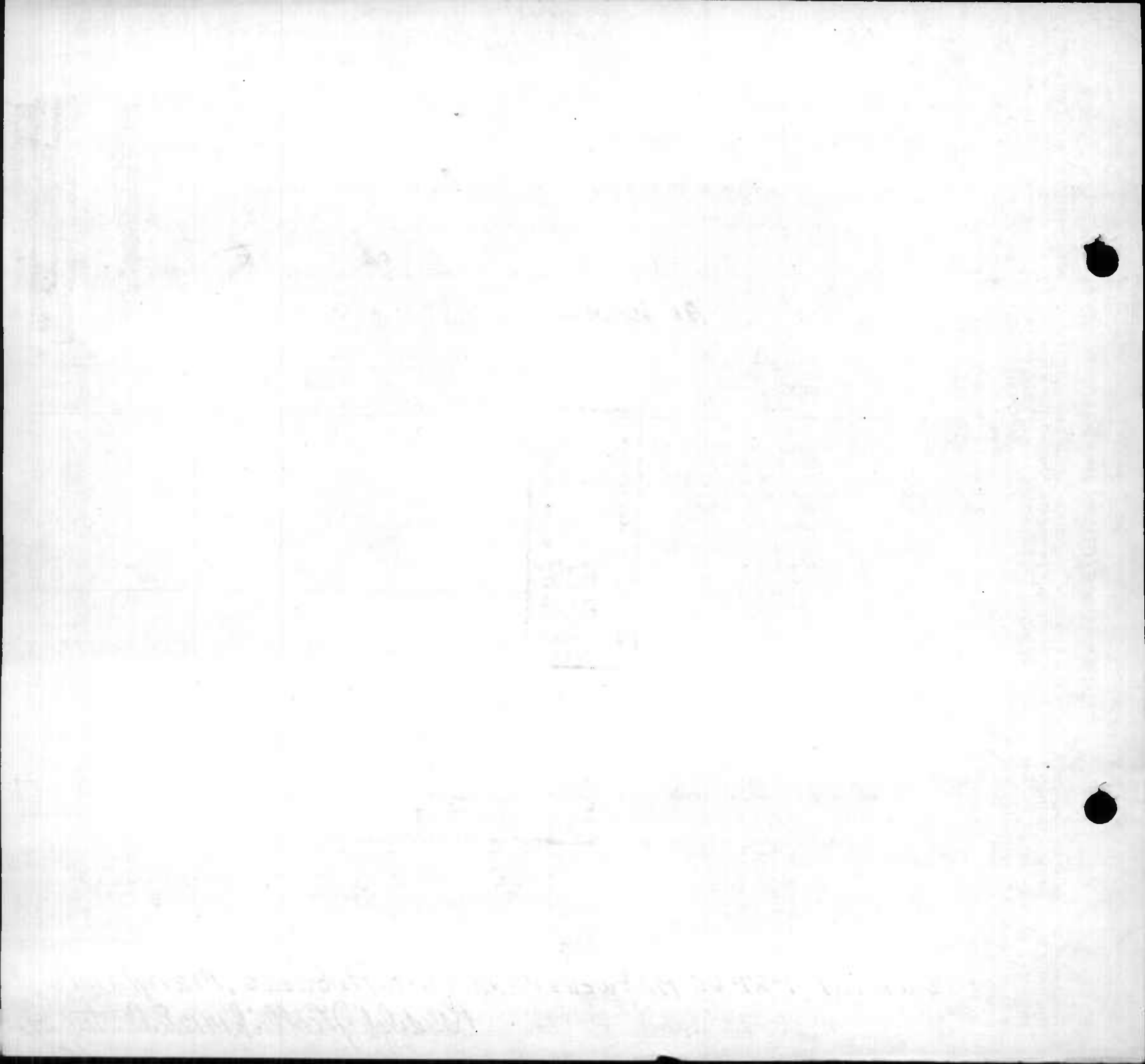
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0894	
BIRTH NO. 65 0894		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mosby, Mary		January 21, 1965 7:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			A. STATE Maryland		
			B. COUNTY 8-06		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			1738 E. Lanvale St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	Negro	Widow	11-28-1896	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		At home		Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Clark			Amy Moore		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		NONE		Sarah Mosby 1738 E. Lanvale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
332-IX			Thrombosis of basilar artery		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19, 1965 to January 21, 1965 that (I) (we) last saw the deceased alive on January 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm B. Vandegrift				23B. DATE SIGNED January 21, 1965	
23C. PHYSICIAN'S NAME (Type) William B. Vandegrift,				23D. ADDRESS 1400 N. Caroline St., Baltimore, Md. 21213	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-25-65		National Cemetery Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1965		Robert E. Farley, M.D.		Randolph J. Collick 1426 Preston St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0895	
BIRTH NO. 65 0895				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) THERESA J. TATE			2. DATE AND HOUR OF DEATH DOA 27 JAN 1965 4 40 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) A. STATE MD B. COUNTY 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5117 KENILWORTH AVE		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) UNMARRIED	8. DATE OF BIRTH 27 MAY 08	9. AGE (In years last birthday) 56	If Under 1 Year Months Days Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HOWARD BOULGIN			14. MOTHER'S MAIDEN NAME SARAH WATERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS CHART - UNION MEMORIAL HOSP	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH VENTRICULAR FIBRILLATION MONUMENTS		INTERVAL BETWEEN ONSET AND DEATH
			19. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 22 JAN 19 65 to 27 JAN 19 65 , that (we) last saw the deceased alive on 27 JAN 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE [Signature]			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 27 Jan 65
23C. PHYSICIAN'S NAME (Type) [Signature]			23D. ADDRESS M.D. [Signature]		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial PK. Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 1412 E. Preston St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0896				
BIRTH NO. 65 0896		M.E. CASE NO.			2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) MARY LOUISE MULLER HORNER					JAN 20 1965 8 ³⁵ P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital (If not in hospital or institution, give street address or location)					A. STATE Md.				
					B. COUNTY 12-05				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1710 St Paul St				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W		8. DATE OF BIRTH 4-1-87	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dometric			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John. Purnell					14. MOTHER'S MAIDEN NAME Kathleen Stinger.				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-14-3622		17. INFORMANT ADDRESS Mrs. Mary Dixon, 215 S. Gilmore Street m21223				
18. 20437-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
					(A) DUE TO Acute Myelogenous Leukemia			Weeks	
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					- Acute Pyelonephritis			WEEKS	
					- Diabetes Mellitus			YRS	
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 11 1965 to JAN 20 1965 , that (I) (we) last saw the deceased alive on JAN 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
23A. SIGNATURE William R. Law								23B. DATE SIGNED 1-21-65	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. LAW M.D.								23D. ADDRESS 301 ST. PAUL PL. BALTO. MD 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 1-25-65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			25B. NAME OF REGISTRAR Robert E. Farley M.D.			25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 ST. Paul Street, 21202			

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 0897					CERTIFICATE OF DEATH					Registered No. 65 0897				
1. NAME OF DECEASED (Type or Print) HAROLD A. KERRY										2. DATE AND HOUR OF DEATH 1/22/65 7⁴⁵ A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PA. B. COUNTY YEADON					C. CITY OR TOWN (If outside city limits, write RURAL and give township) YEADON				
D. STREET ADDRESS (If rural, give location) 948 DUNCAN AVE					5. SEX M					6. RACE W				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH 9/2/XXX08					9. AGE (In years last birthday) 56				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Executive					10B. KIND OF BUSINESS OR INDUSTRY Beck's Meat Foods					11. BIRTHPLACE (State or foreign country) Westville, Penn				
12. CITIZEN OF WHAT COUNTRY? U S.A.					13. FATHER'S NAME John Kerry					14. MOTHER'S MAIDEN NAME Julia Alburg				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 121-12-4082					17. INFORMANT Goldie Kerry, 948 Duncan Ave., YEADON, Pa.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420A-260X Anterior wall myocardial infarction										INTERVAL BETWEEN ONSET AND DEATH 25 min				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Diabetes mellitus										15 YRS.				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 22 19 65 to Jan 22 19 65 , that (I) (we) last saw the deceased alive on Jan 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Herbert A. Kushner										23B. DATE SIGNED Jan. 22, 1965				
23C. PHYSICIAN'S NAME (Type) HERBERT A. KUSHNER										23D. ADDRESS University Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL					24B. DATE 1-22-65					24C. NAME OF CEMETERY or CREMATORY Rochester, New York				
24D. LOCATION (City, town, or county) (State)					25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965					25B. NAME OF REGISTRAR Robert E. Farley, M.D.				
25C. FUNERAL DIRECTOR Wm. Cook, Inc.					25D. ADDRESS 1217 St. Paul Street 21202									

UNIVERSITY HOSPITAL
WARRIED
d/s 10
2d
AIR JUNCTION AVE
JERSEY

> 1/4
12 YRS

on

X
University Hospital

Robert A. Kohn
JAN 1 1978

Y

LS: 42-55-96
G. 4-30-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0898

BIRTH NO. 65 0898

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

H.

Bertha Gillette

2. DATE AND HOUR OF DEATH

January 21, 1965

8:00

A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Harford

Balts.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

RURAL

Timonium,

53-00

D. STREET ADDRESS (If rural, give location)

2405 Spring Lake Drive

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-25-07

9. AGE (In years
last birthday)

57

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Connecticut

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

S. Alfred Hedstrom

14. MOTHER'S MAIDEN NAME

Victoria Thor

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS
John P. Gillette, 2405 Spring Lake Dr. Timonium

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

199.21

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pulmonary Embolus

ANTECEDENT CAUSES

(B) DUE TO

Metastatic Carcinoma

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Inotify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 8, 19 65 to January 21, 19 65,
that (I) (we) last saw the deceased alive on January 21, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Howard K. Rathbun

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

January 21, 1965

23C. PHYSICIAN'S
NAME (Type)

Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-23-65

24C. NAME OF CEMETERY or CREMATORY

Dulaney Valley Gardens

24D. LOCATION

(City, town, or county)

Baltimore County

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

25B. NAME OF REGISTRAR

Robert E. Fisher

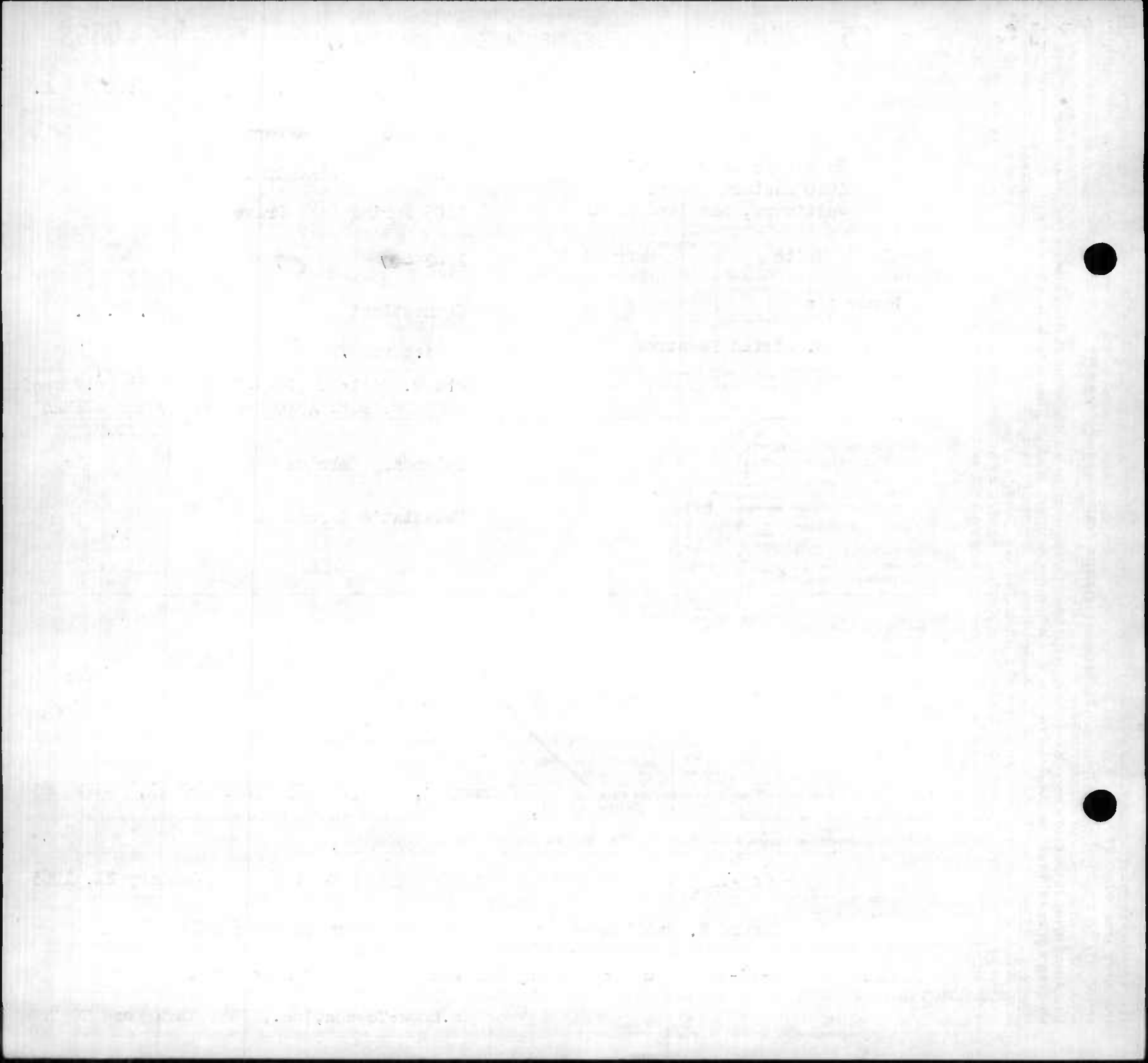
25C. FUNERAL DIRECTOR

Wm. Cook, Towson, Inc., 1050 York Road TOWSON

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

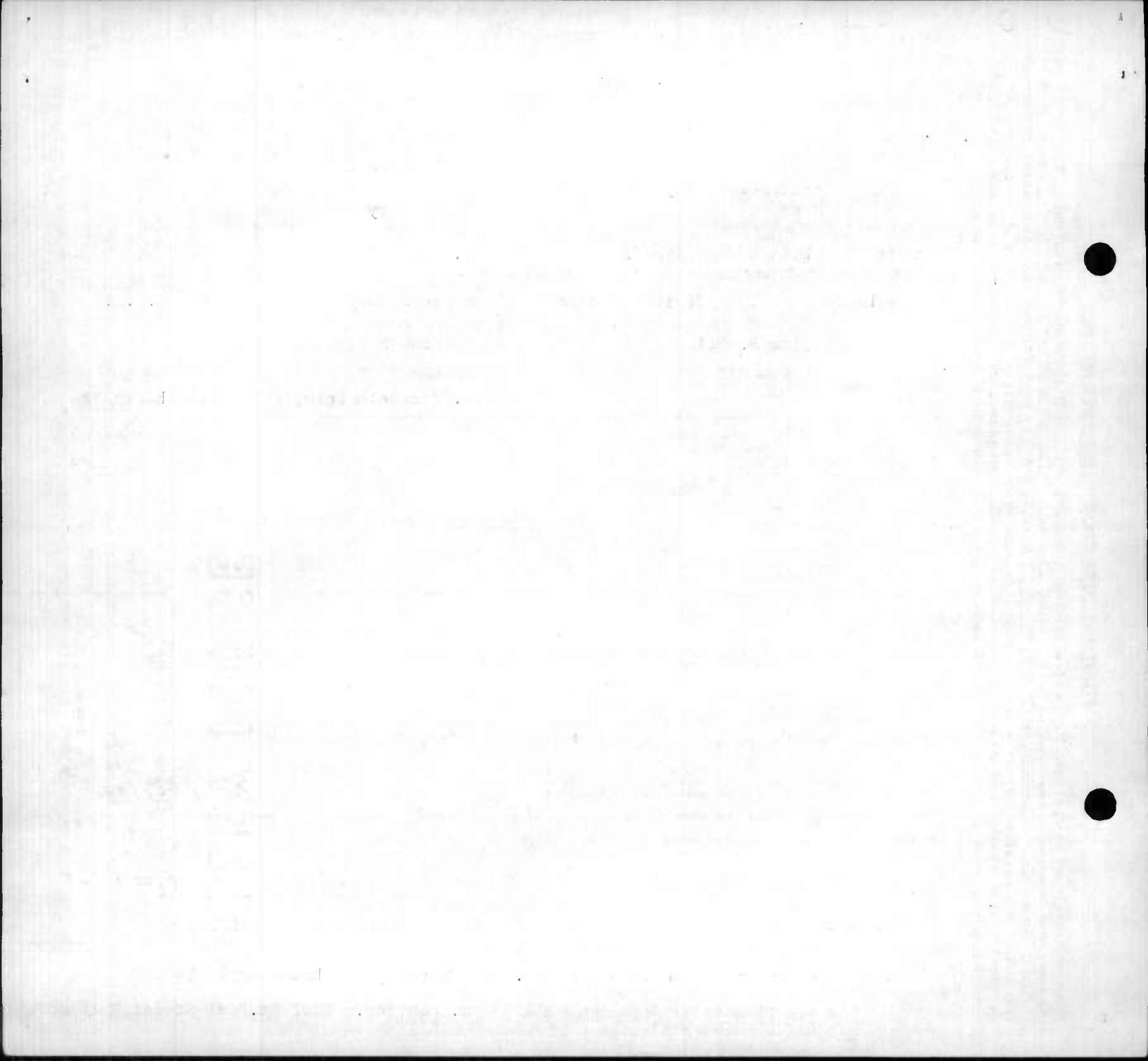
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

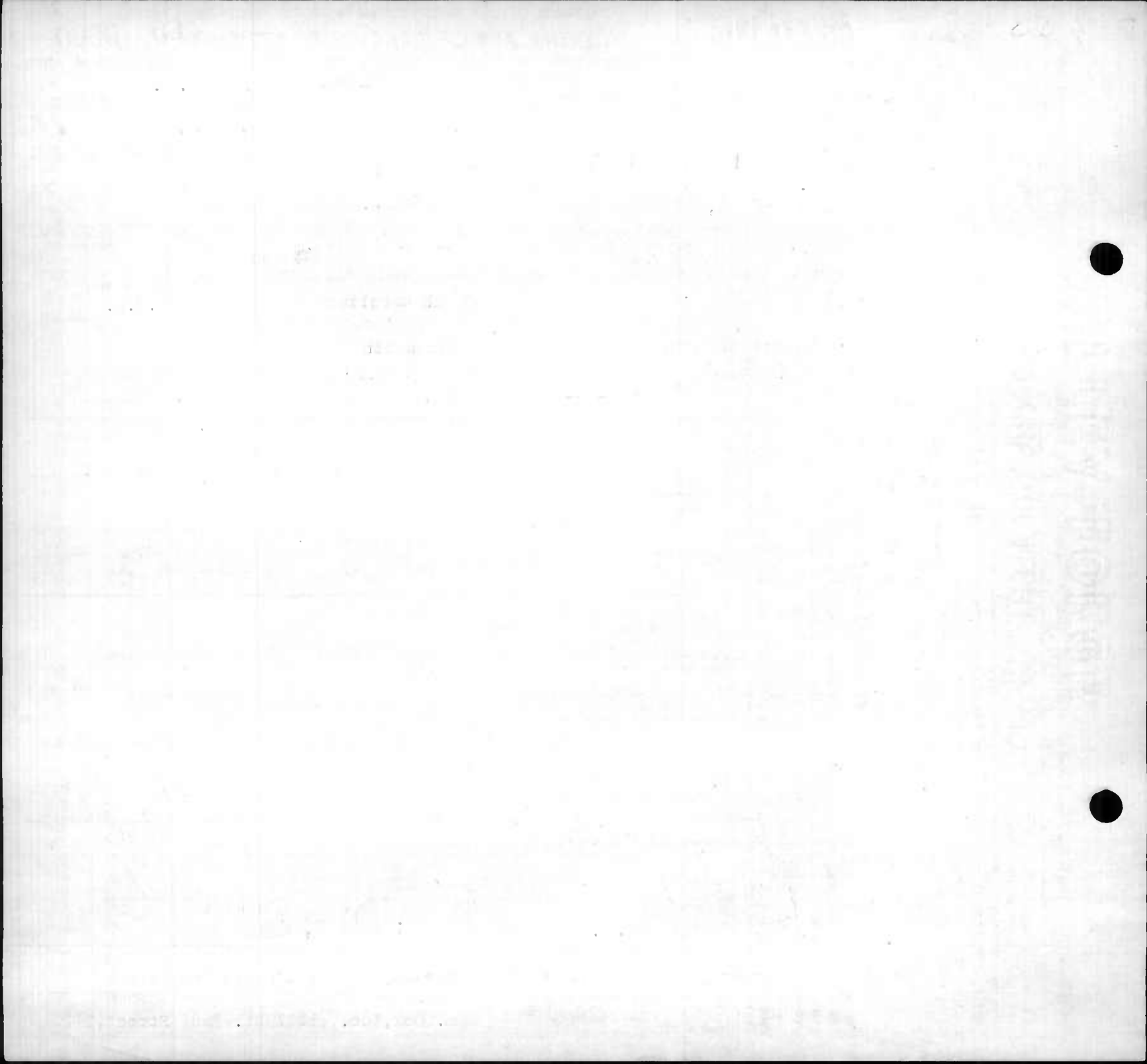
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0899				
BIRTH NO. 65 0899									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) William M. Helm					2. DATE AND HOUR OF DEATH January 21, 1965				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 2309 Maryland Avenue Baltimore, Maryland 21218					A. STATE Maryland B. COUNTY 12-06				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218				
					D. STREET ADDRESS (If rural, give location) 2309 Maryland				
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH Feb. 12, 1909	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10B. KIND OF BUSINESS OR INDUSTRY General Motors		11. BIRTHPLACE (State or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Helm					14. MOTHER'S MAIDEN NAME Lida Mills				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elizabeth Helm, 1752 North Rhodes St. ARLINGTON, Va				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Congestive heart failure					INTERVAL BETWEEN ONSET AND DEATH months				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Antemortalestic heart disease years				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Decayed condition years				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/12/64 19 to 1/21/65 19, that (I) (we) last saw the deceased alive on 1/9/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature] M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/22/65	
23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN					23D. ADDRESS M.D. 5211 Harford Road, Baltimore				
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 1-22-65		24C. NAME OF CEMETERY or CREMATORY Chattanooga Mem. Park Cemetery		24D. LOCATION (City, town, or county) (State) Chattanooga, Tenn			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, Baltimore					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

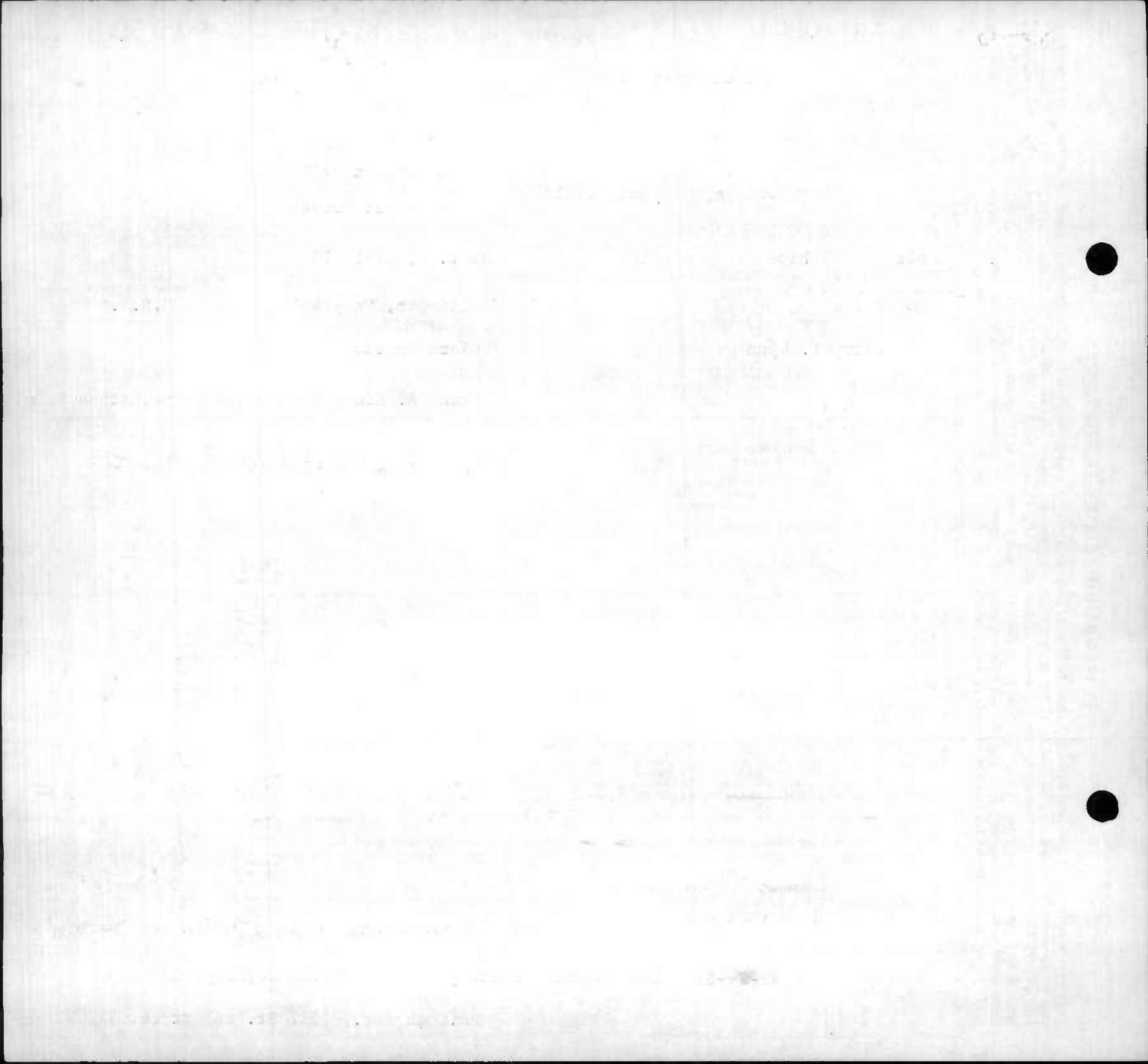
BIRTH NO. 65 0900				CITY HEALTH DEPARTMENT		Registered No. 65 0900	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BULLMAN, HALLIE S.				2. DATE AND HOUR OF DEATH 1-21-65 1:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE 5, MD				A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2			
				D. STREET ADDRESS (If rural, give location) 1716 ST. PAUL STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED		8. DATE OF BIRTH 4-10-01	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Booker Bullman				14. MOTHER'S MAIDEN NAME Elizabeth (unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 250-16-1352		17. INFORMANT (WIFE) MATTIE BULLMAN ADDRESS 1716 ST. PAUL ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of pharynx INTERVAL BETWEEN ONSET AND DEATH 2 years							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/19 19 65 to 1/21 19 65 , that (I) (we) last saw the deceased alive on 1/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Signed 1:05 PM 1/21/65							
23A. SIGNATURE Carl E. Bredenberg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/21/65	
23C. PHYSICIAN'S NAME (Type) CARL E. BREDEBERG M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE 5, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-25-65		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm. COOK, Inc., 1217 St. Paul Street, 21202			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

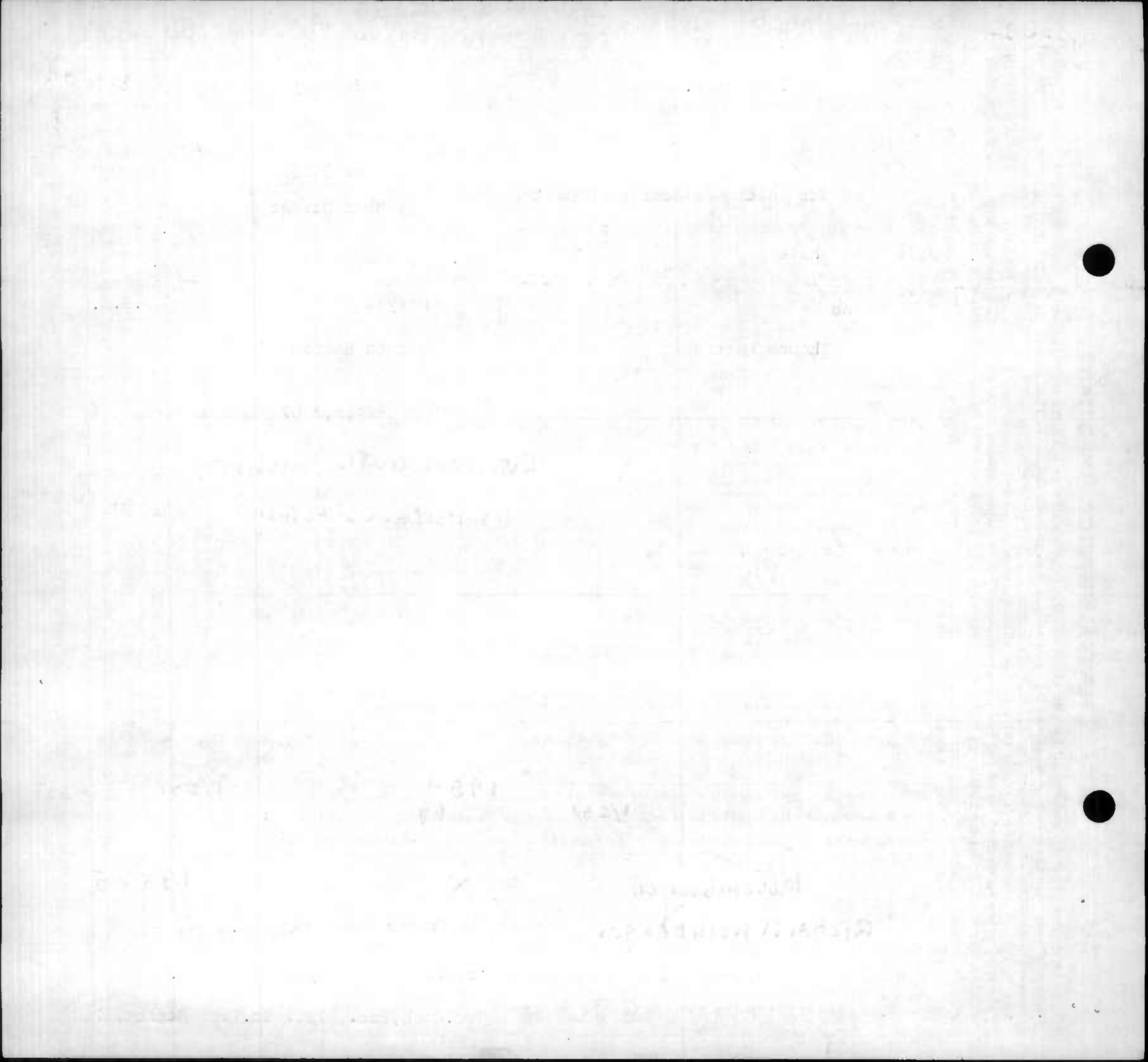
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0901				
BIRTH NO. 65 0901									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		Helen Irene King				2. DATE AND HOUR OF DEATH January 23, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 118 Locust Drive Catonsville, Maryland 21228				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville 21228			
						D. STREET ADDRESS (If rural, give location) 118 Locust Drive			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH Sept. 8, 1891	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry L. Wynn				14. MOTHER'S MAIDEN NAME Clara Knotts					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Frank A. King, 118 Locust Drive, Catonsville					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Bladder (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH months					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from Sept 1965 to 1/23 1965 , that (I) (we) last saw the deceased alive on 1/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE James Nolan				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) J. J. NOLAN				23D. ADDRESS M.D. 416 Kensington Rd. Baltimore 29, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR R. B. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

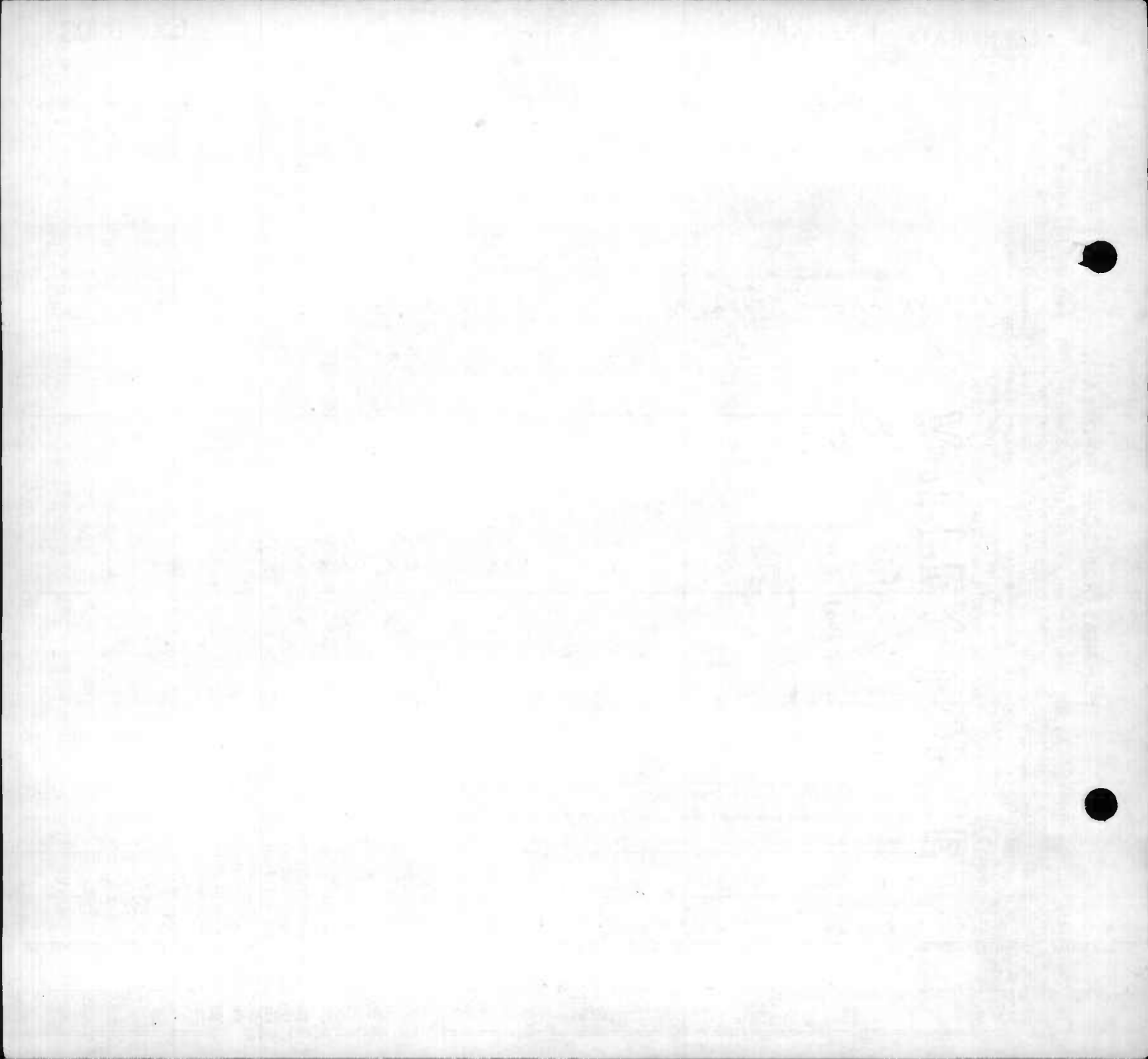
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0902	
BIRTH NO. 65 0902				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Clarence F. Magers				January 23, 1965 2:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital				A. STATE Maryland B. COUNTY 2404	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21230	
				D. STREET ADDRESS (If rural, give location) 1819 Belt Street	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Oct. 30, 1889	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Magers			14. MOTHER'S MAIDEN NAME Lucinda Harris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Clarence Magers, 2307 Lincoln Avenue, 21219	
18. 4221 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardio-					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Parvular disease					
INTERVAL BETWEEN ONSET AND DEATH about 10 yrs					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1954 19 to 1/23/ 19 65 , that (I) (we) last saw the deceased alive on 1/23/ 19 64 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Weinberger				23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) Richard Weinberger				23D. ADDRESS 912 Brooks Lane, Baltimore 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-26-65	24C. NAME OF CEMETERY or CREMATORY Pine Grove United Brethren		24D. LOCATION (City, town, or county) (State) Rayville, Balto.Co	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

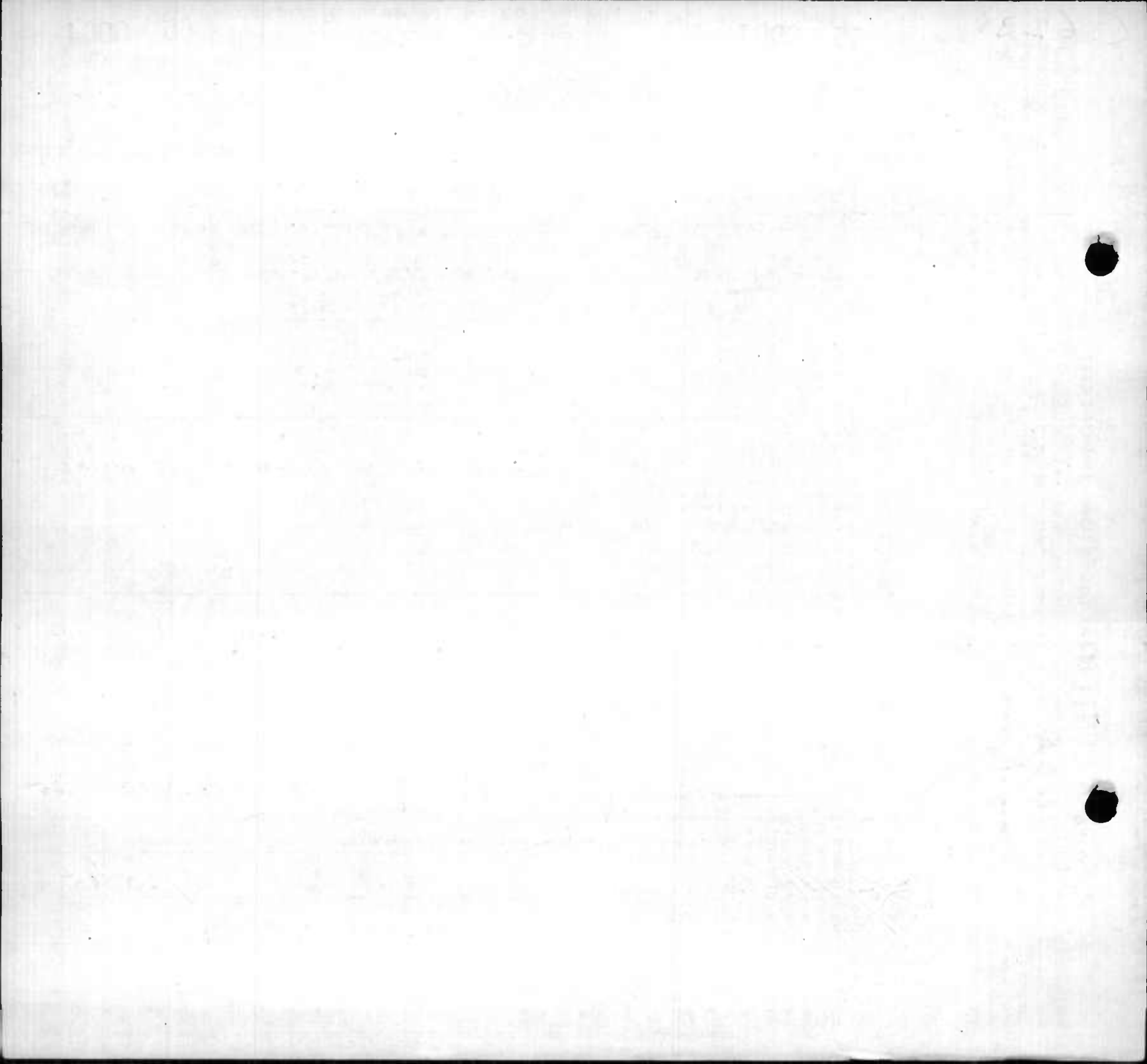
BIRTH NO. 65 0903				BALTIMORE CITY HEALTH DEPT.		Registered No. 65 0903	
CERTIFICATE OF DEATH M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CHARLES CASPER FITZBERGER 2. DATE AND HOUR OF DEATH 1-25-65 4:30 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MD B. COUNTY 26-10			
CHURCH Home & Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 433 N. Bouldin St							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-14-04	9. AGE (In years last birthday) 60	11. BIRTHPLACE (State or foreign country) MD, Baltimore	12. CITIZEN OF WHAT COUNTRY? USA	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BETHLEHEM Steel Co. Mechanic
13. FATHER'S NAME CHRISTIAN FITZBERGER			14. MOTHER'S MAIDEN NAME DORTHEA BURCH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212 05 8574		17. INFORMANT 433 North Bouldin Street Mrs Mildred E. Fitzberger		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) CARDIAC ARREST			
ANTECEDENT CAUSES				(B) CHRONIC BRONCHIAL ASTHMA, EMPHYSEMA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) PNEUMONIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-3-1964 to 1-25-1965 , that (I) (we) last saw the deceased alive on 1-25-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ephraim B. Barzaga M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA				23D. ADDRESS CHURCH Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

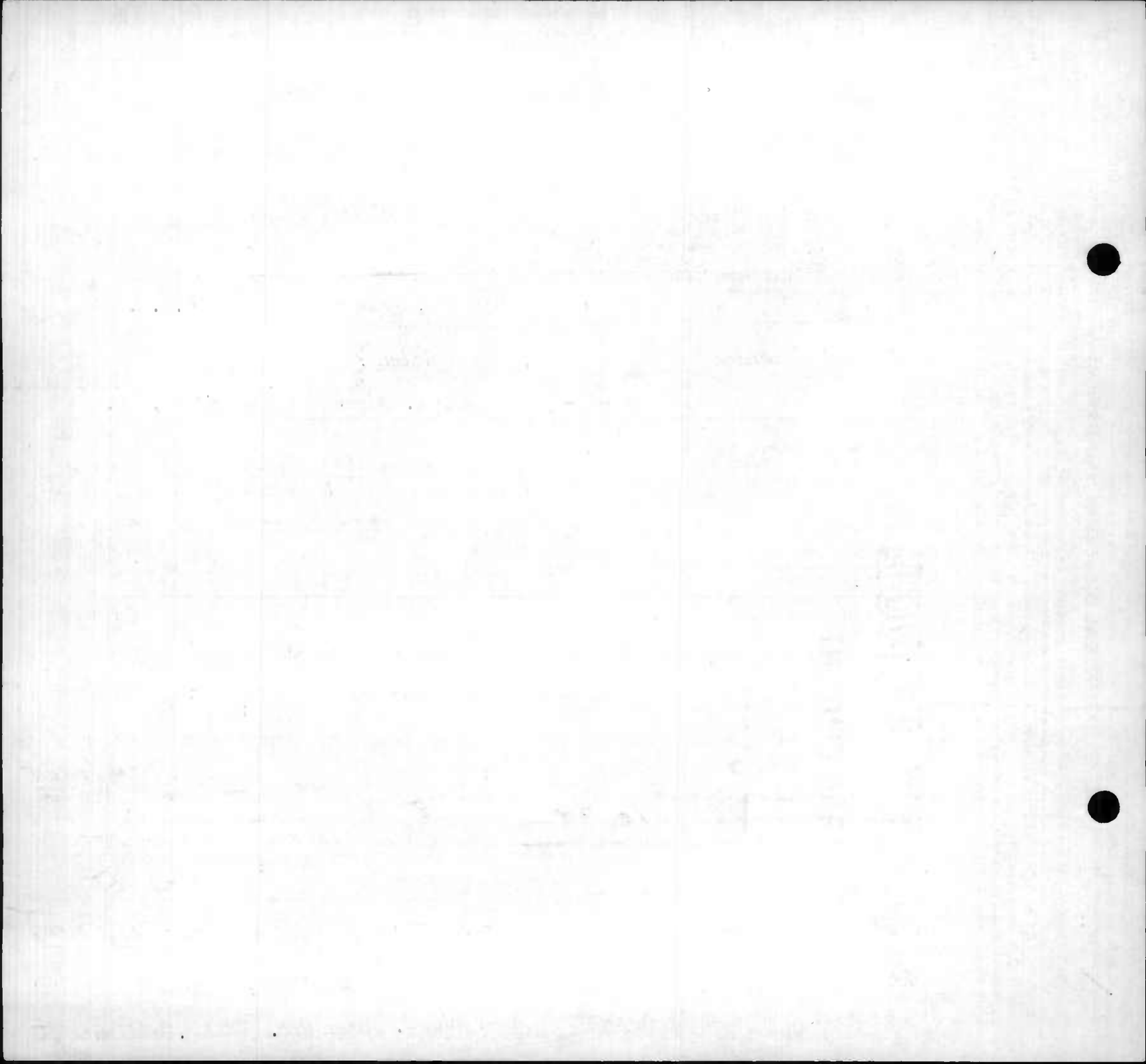
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0904</u>	
BIRTH NO. <u>65 0904</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HARRY WALTER CRIST</u>		2. DATE AND HOUR OF DEATH <u>January 23, 1965</u> <u>2:15 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>9-06</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1828 East 31st. Street</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, 21218</u>			
		D. STREET ADDRESS (If rural, give location) <u>1828 East 31st. Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 26, 1889</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John C. Crist</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Lins</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes World War # 1</u>		16. SOCIAL SECURITY NO. <u>215 09 2934</u>		17. INFORMANT ADDRESS <u>1828 East 31st Street 21218</u> <u>Mrs Mildred Knox Crist</u>	
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebro-vascular Thrombosis</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Coronary Occlusion & Myocardial Damage</u>		<u>10 weeks</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 3</u> 19 <u>64</u> to <u>Jan 23</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Loy M. Zimmerman</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE/SIGNED <u>1/25/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman</u>				23D. ADDRESS M.D. <u>3202 Harford Road Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/26/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn Cemetery</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HENRY SANDER & SONS INC.</u> <u>BALTIMORE MARYLAND 21213</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

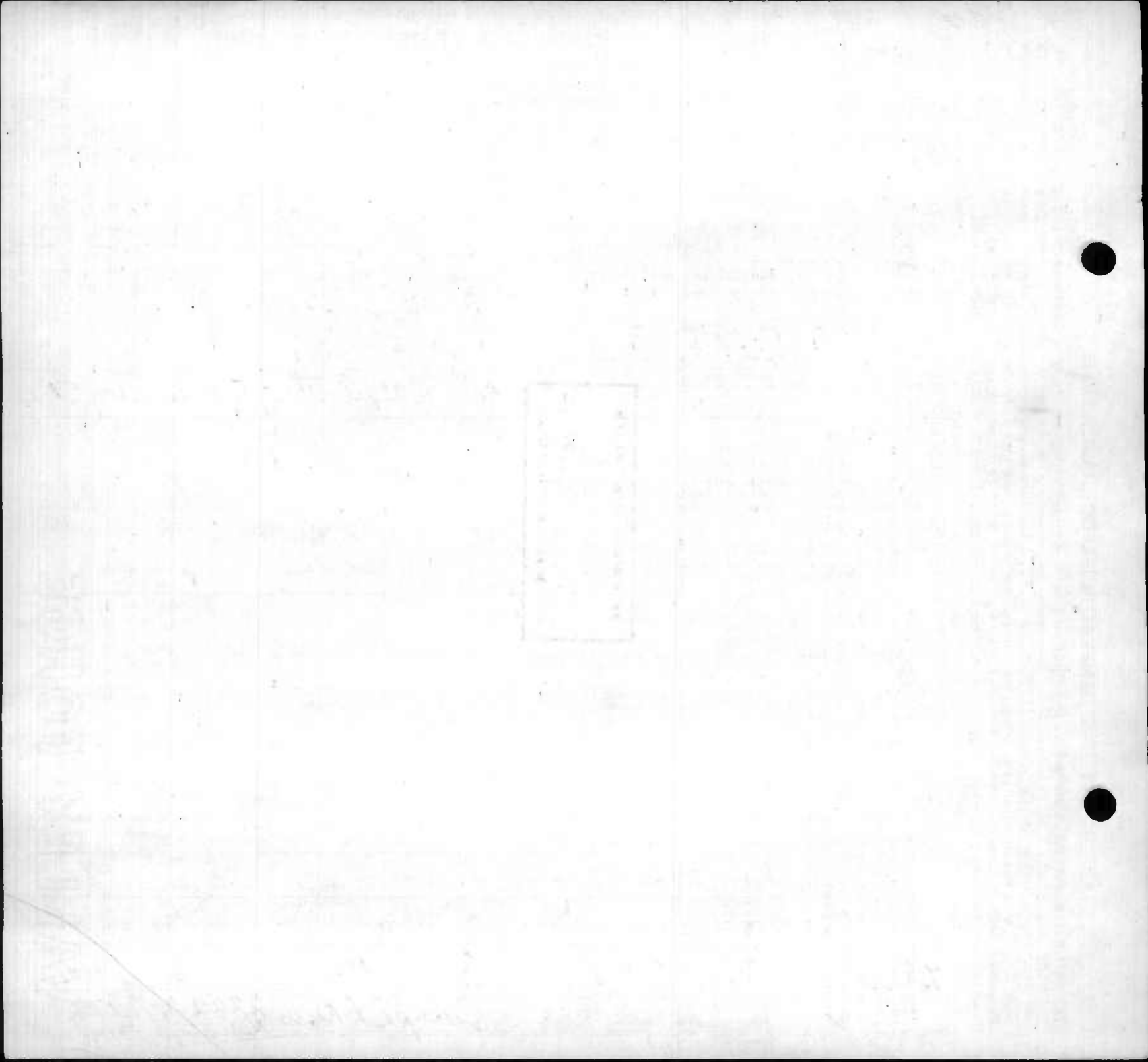
BIRTH NO. 65 0905				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0905	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>George D. Alexander</i>				2. DATE AND HOUR OF DEATH <i>1/24/65</i> <i>8 A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>113 Rochester Place</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>113 Rochester Place</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Separated</i>	8. DATE OF BIRTH <i>5/15/1887</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Crete, Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Dimitrios Alexander</i>				14. MOTHER'S MAIDEN NAME <i>Helen ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-72-8314A</i>		17. INFORMANT <i>John D. Alexander</i> ADDRESS <i>11810 Henry Fleet Drive Rockville, Md.</i>			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Heart Coronary Occlusion</i> DUE TO <i>Coronary Artery Disease</i> (B) <i>Atherosclerotic Cardio-Vascular Disease</i> DUE TO <i>Disease</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>unknown</i> <i>unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>August 3</i> 19 <i>49</i> to <i>January 24/1965</i> that (I) (we) last saw the deceased alive on <i>12/24</i> 19 <i>64</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>8 Am. - 1/24/65</i>							
23A. SIGNATURE <i>Philibert Artigiani</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/26/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Philibert Artigiani</i> M.D.				23D. ADDRESS <i>2305 Mayfield Ave - Balt. 13. Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/27/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran Inc. 3000 E. Baltimore St.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

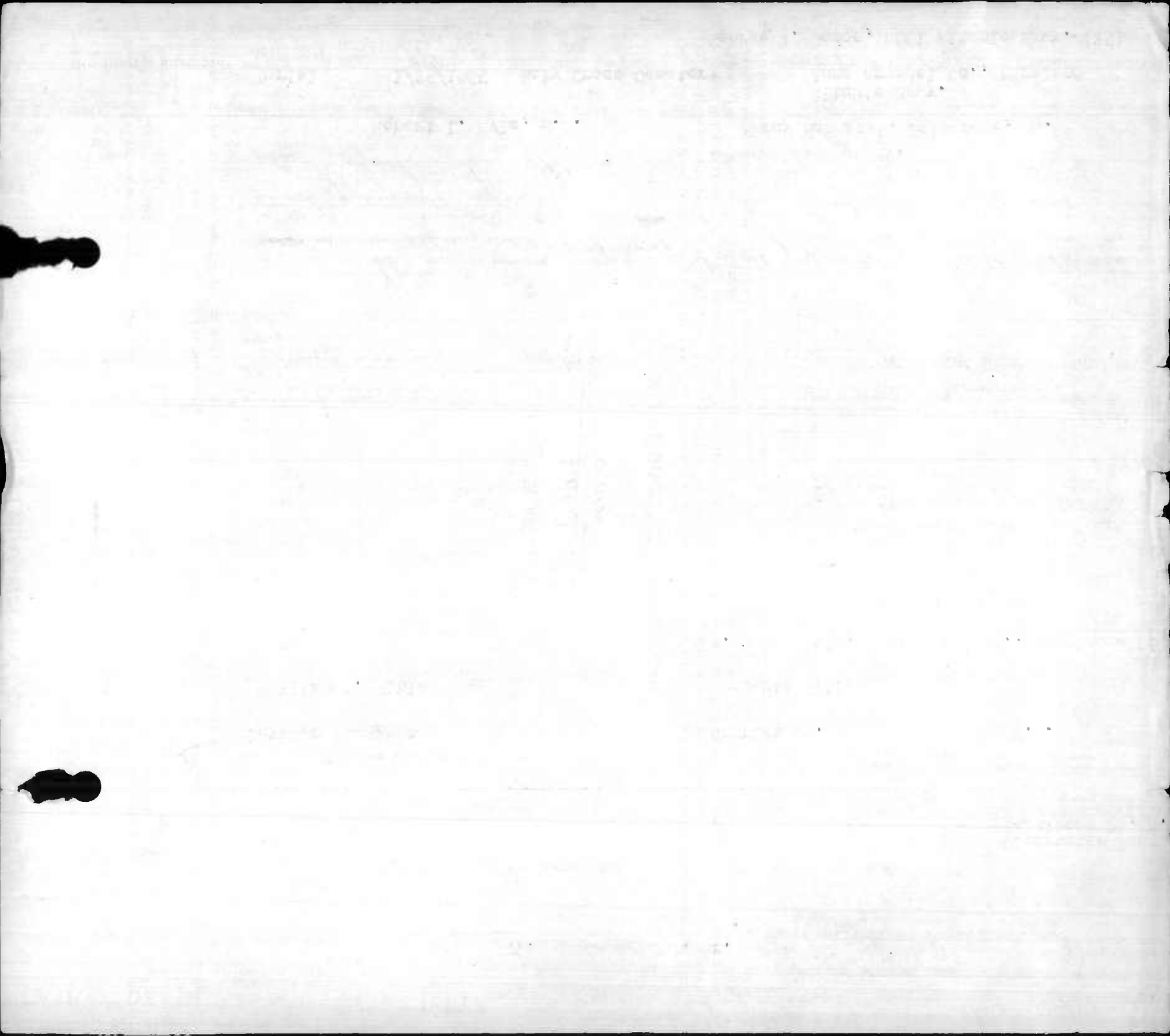
BIRTH NO. 65 0906		CITY HEALTH DEPARTMENT		Registered No. 65 0906	
M.E. CASE NO. 65 0906		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Anthony, Diane</i>			2. DATE AND HOUR OF DEATH <i>1/20/65 6:50 AM</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>2007</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>D.O.A. Lutheran Hospital of Maryland</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>8 N. Morley St. 29 MORLEY</i>		
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>Aug. 14, 1952</i>	9. AGE (In years last birthday) <i>2 yrs</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Alexander Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Betty Spirey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Betty Anthony 8 N. Morley St.</i>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <i>pulmonary edema bronchial asthma</i>		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/20</i> 19 <i>65</i> to <i>1/20</i> 19 <i>65</i> . that (I) (we) lost saw the deceased alive on <i>D.O.A. 1/20</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hossein Golpira</i>				23B. DATE SIGNED <i>1/21/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>HOSSEIN GOLPIRA</i>		23D. ADDRESS <i>Lutheran Hospital of Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/23/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Westport (Baltimore) Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Joseph L. Russ</i>		25D. ADDRESS <i>2222 W. Montrose Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0907	
BIRTH NO. 65 0907				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANCIS K. WIBLE, Sr.		1-21-65 5 ²⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
MERCY HOSPITAL				MARYLAND - BALTIMORE A.O.C.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE	
				D. STREET ADDRESS (If rural, give location)	
				8201 HOLLY RD. Clearwater Beach Baltimore 26, Md.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	MARRIED	10-9-01	63	Elevator Mechanic
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
William M. Wible			Roberta Ellis		U.S.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Mrs. Ruby Wible, 8201 Holly Rd., Baltimore 26
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
434.3 I		(A) Myocardial Infarction		3am	
ANTECEDENT CAUSES		(B) Mabel Hypertension & Irregular Skull - 4hr.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		(C) Maxine Kementz		6 hr.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
1-21-65		Constrictive Pericarditis		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		No		No	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
No		No		No	
22. I certify that (if at this hospital) attended the deceased from 1-9-65 to 1-21-65. (We) lost saw the deceased alive on 1-21-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert L. Dyle, M.D.				1-22-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Robert L. Dyle, M.D.				Mercy Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/25/1965		Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR ADDRESS	
Ritchie Hgwy. Anne Arundel Co., Maryland		Robert E. Farley, MA		George J. Gonce, 4001 Ritchie Hgwy. (25)	
25A. DATE FILED BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS					
JAN 26 1965					



1

65 0908

BALTIMORE CITY HEALTH DEPARTMENT

65 0908

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

59377

1. NAME OF DECEASED
(Type or Print)

TILLIE

SCHEME

2. DATE AND HOUR PRONOUNCED DEAD

January 21, 1965

8:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

119 E. West Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 17, 1888

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Funeral Director

10B. KIND OF BUSINESS OR INDUSTRY

Funeral

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Joseph Scheme

14. MOTHER'S MAIDEN NAME

Tillie Harle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-20-0610

17. INFORMANT

ADDRESS

Mr. John Carey, 1270 Meridene Dr. (12)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Cardiac Tamponade

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Rupture of Aorta.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

119 E. West Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

January 21 1965 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell out of 2nd floor window.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/25/1965

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy., A. A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

George J. Gonce 4001 Ritchie Hwy. (25)

WALL 15011013

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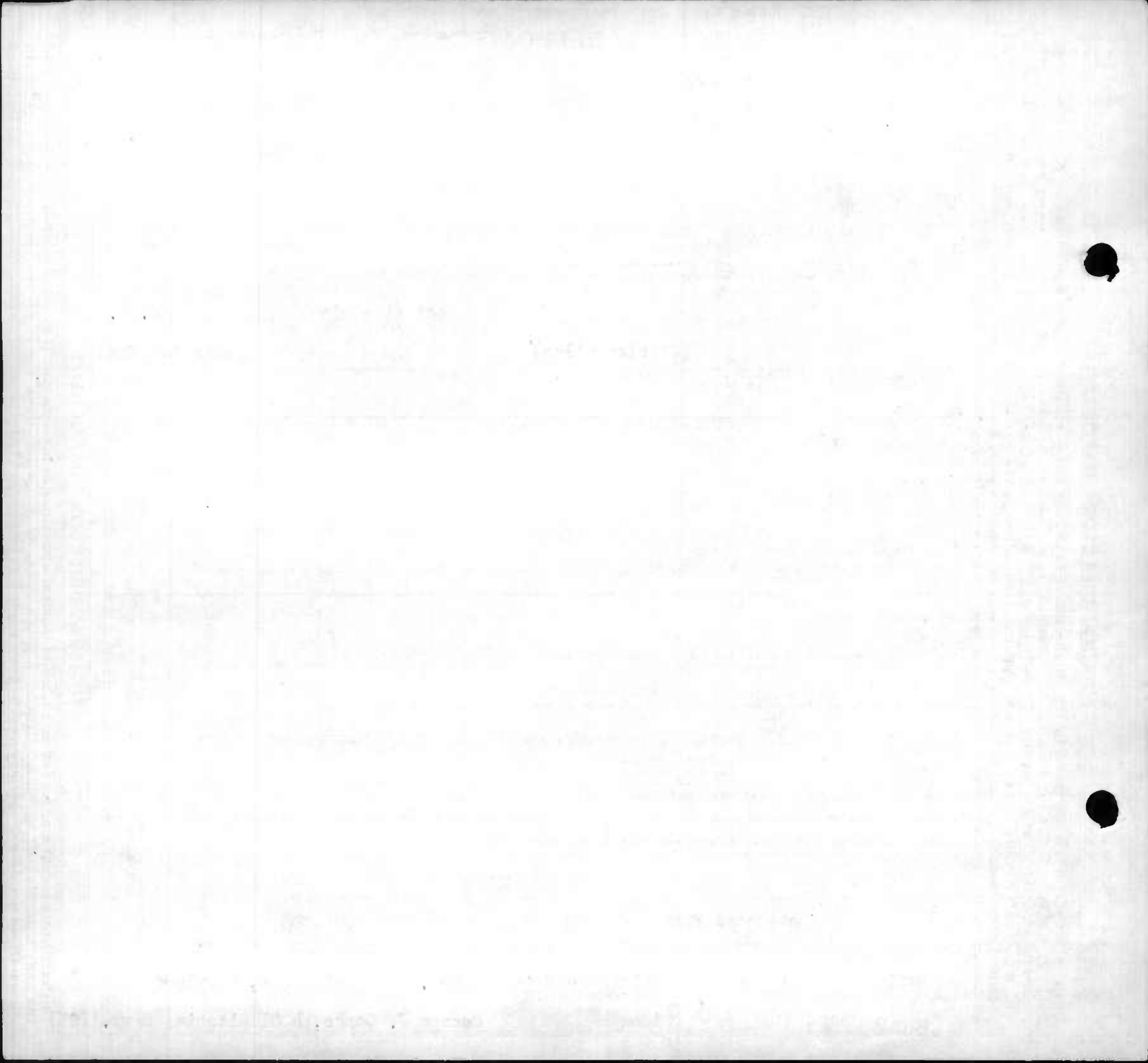
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0909	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0909					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BRENDA Sue WILES			2. DATE AND HOUR OF DEATH 1. 20. 65 10:40 pm.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5236, 4th St. 52-00		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 2. 20. 49	9. AGE (In years last birthday) 15	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Charles Wiles (Charles Wiles)			14. MOTHER'S MAIDEN NAME Doris Cox (Doris Ann Cox)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Doris Cox Wiles			ADDRESS S/A		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 330X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Subarachnoid hemorrhage DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1. 20. 1965 to 1. 20. 1965 , that (I) (we) last saw the deceased alive on 1. 20. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) W (did) (did not) view the body after death.					
23A. SIGNATURE Thavatchai Fuangvudhiran M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) THAVATCHAI FUANGVUDHIRAN M.D.				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/1965		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy. (25)			



34-27-91, NS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0910

BIRTH NO. 62-65-17385

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Charon Fowler (Sharon)

2. DATE AND HOUR OF DEATH

1-23-65

1:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1205 Patterson Park Avenue #21213

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

7-9-62

9. AGE (In years
last birthday)

2 1/2

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Theo. Fowler Jr.

14. MOTHER'S MAIDEN NAME

JEANNETTE Lightner

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Subacute Bacterial Endocarditis
DUE TO

4 Months

(B) Atrioventricular - Shunt
DUE TO

1 1/2 Years

(C) Hydrocephalus

2 1/2 Years

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2 11-16-1962

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED Obstructive right
Ventriculo-atrial shunt

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-22 19 65 to 1-23 19 65,
that (I) (we) last saw the deceased alive on 1-23 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wayne Klein

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-23-65

23C. PHYSICIANS
NAME (Type)

Dr. Wayne Klein

23D. ADDRESS

M.D. B.C.H. 4940 Eastern Avenue # 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1- -65

24C. NAME OF CEMETERY or CREMATORY

MT. CALVARY Cem.

24D. LOCATION

A.A. County

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

25B. NAME OF REGISTRAR

Robert E. Johnson

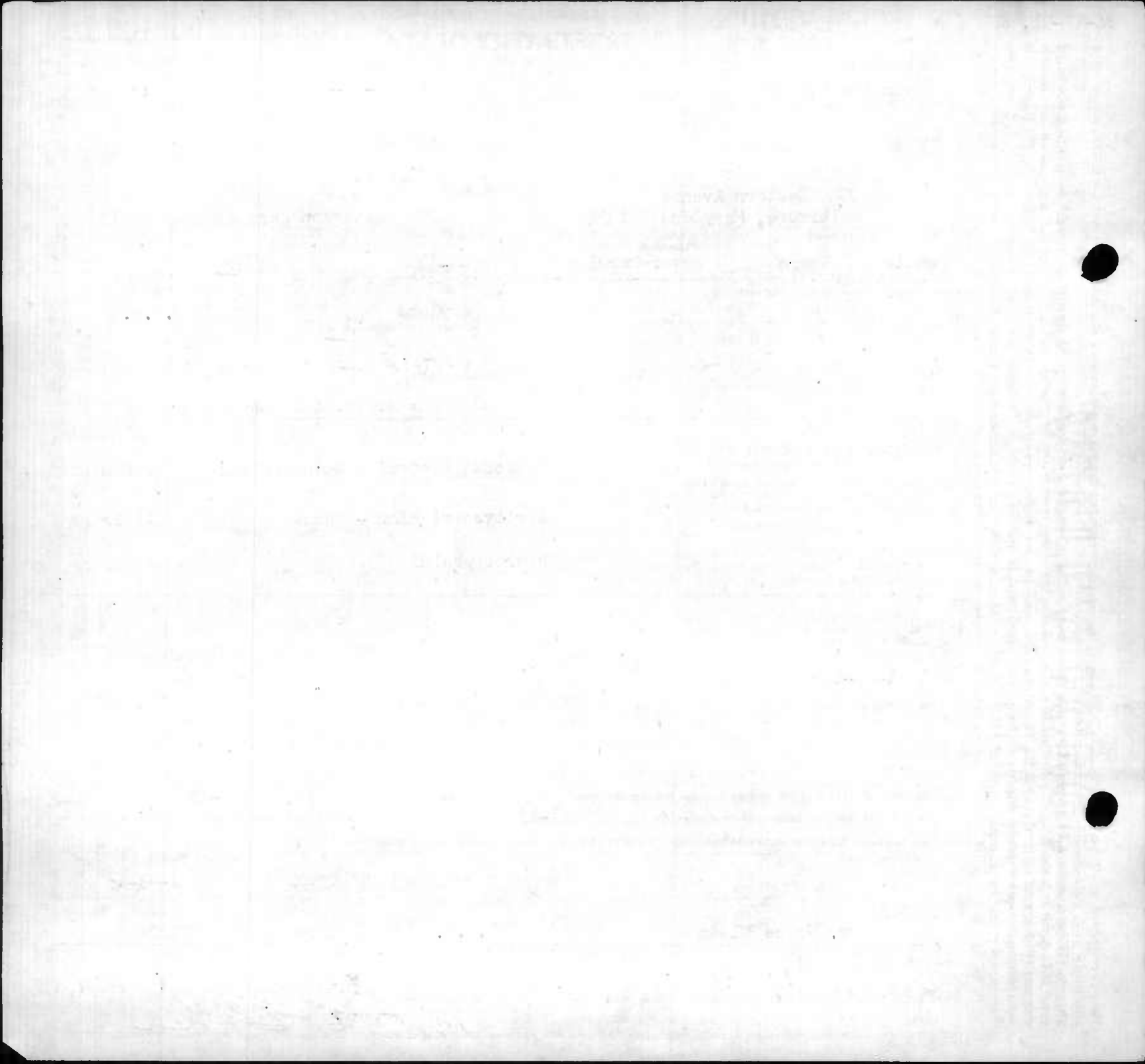
25C. FUNERAL DIRECTOR

Miller E. Elchen

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

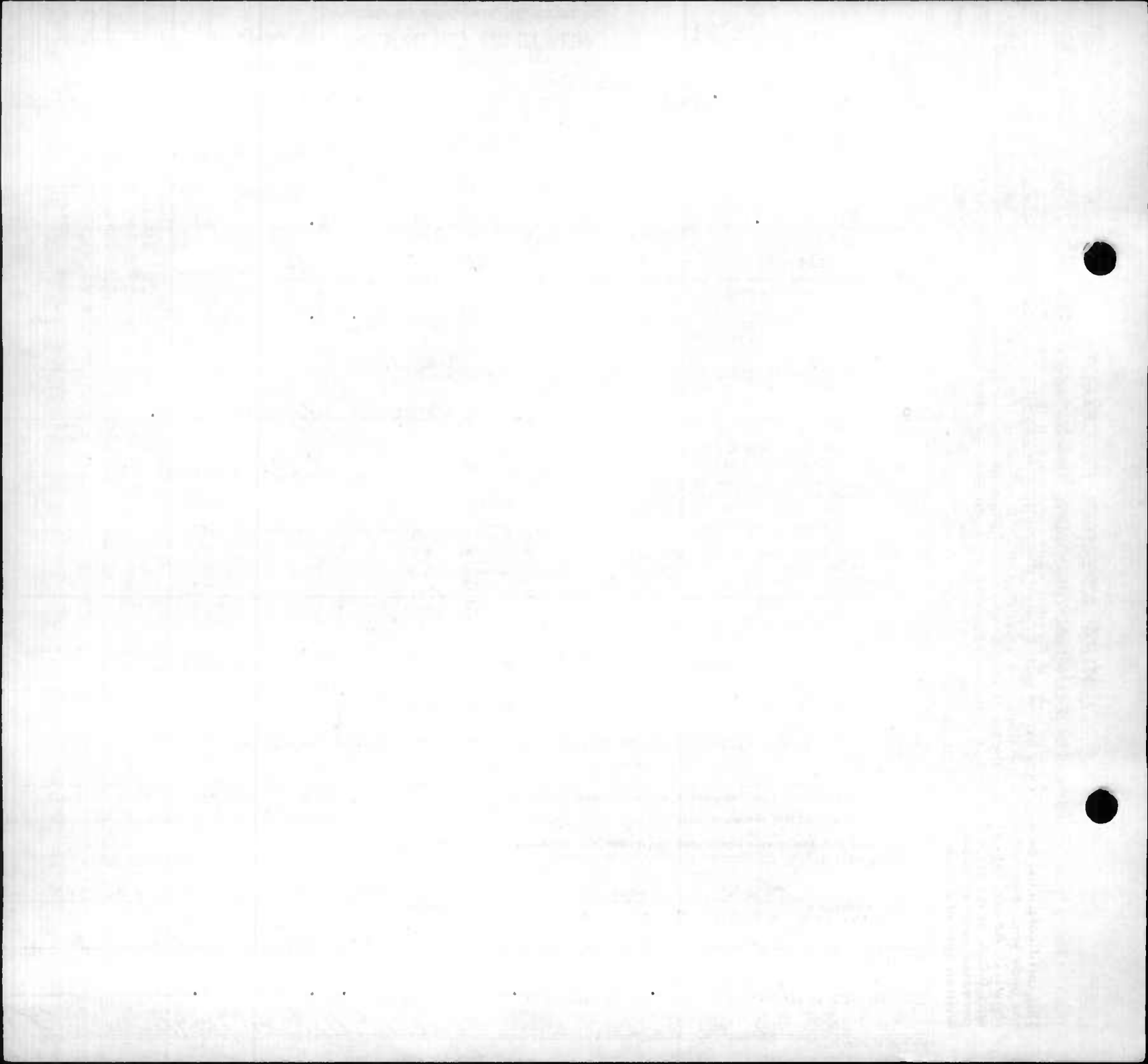
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

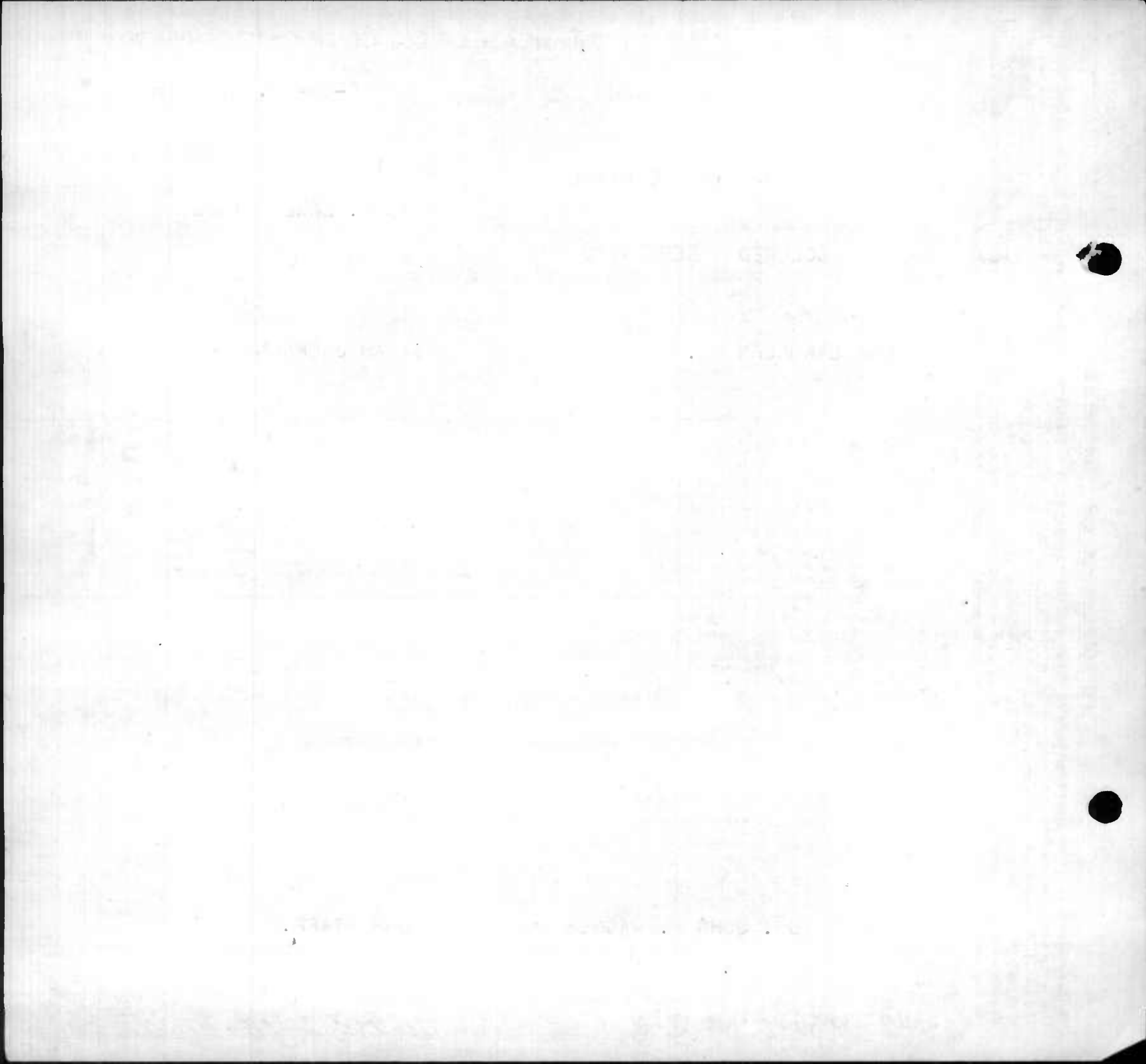
BIRTH NO. 65 0911				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0911	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Harry B. Epps				1/20/65 10 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
908 Rutland Ave.				Maryland		7-04	
5. SEX Male				6. RACE Colored			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 2/1/1881			
9. AGE (In years last birthday) 83				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			
11. BIRTHPLACE (State or foreign country) Nottaway Cty. Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME David Epps				14. MOTHER'S MAIDEN NAME Dinah ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Emma Epps				ADDRESS 908 Rutland Ave.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO Arterio. Sclerotic Heart Disease 1958			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO Generalized Arterio Sclerosis			
ANTECEDENT CAUSES				(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				general Sclerotic Changes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
none				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/17 1958 to Jan 20 1965, that (I) (we) last saw the deceased alive on Jan 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Ralph J. Young				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/21/65	
23C. PHYSICIAN'S NAME (Type) Ralph J. Young				23D. ADDRESS 1532 E. Monument St. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. County Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Frank T. Erickson		ADDRESS 11297 M. Carline St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

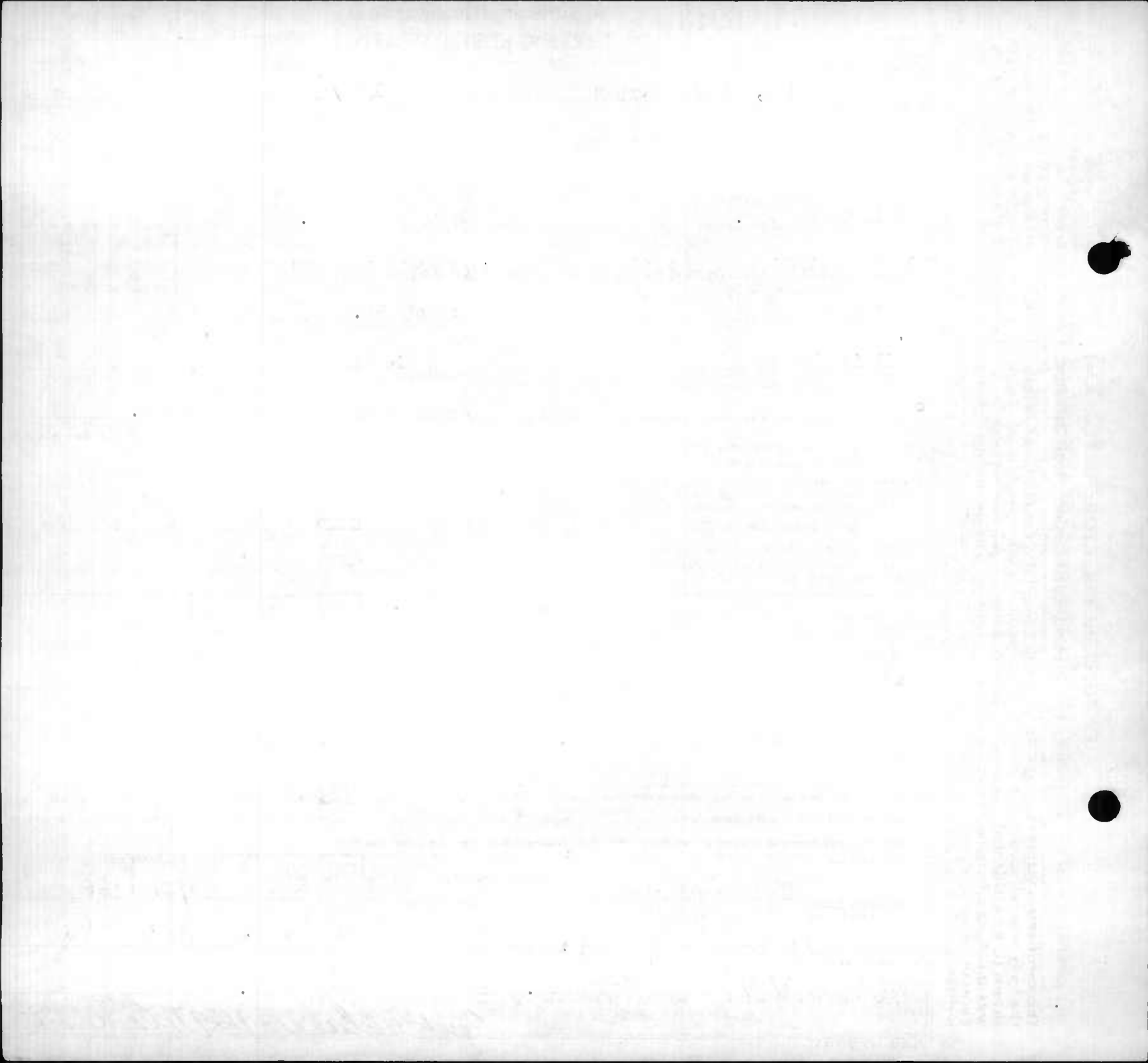
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0912					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 0912				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
HUGH LANGHORN					1-23-65. 2:10 PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
THE JOHNS HOPKINS HOSPITAL					MARYLAND 7-04				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					1813 E. EAGER STREET				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		COLORED		SEPARATED		March 13, 1900		64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Unemp. Laborer					Wiltaway County Va.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
HUGH LANGHORN SR.					SARAH JACKSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
Yes					150-12-1010		Deceased Johnson 1813 E Eager St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					Pneumonia				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					Carcinoma of Rectum				
					(C) DUE TO				
II					INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3 12/29/64		Ca of Rectum			yes		no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
no									
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
none		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 12/23 1964 to 1/23 1965, that (I) (we) last saw the deceased alive on 1/23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
DR. JOHN R. WAGNER M.D.					JHH STAFF.			1/23/65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
DR. JOHN R. WAGNER					JHH STAFF.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1/26/65		Mt Calvary Am		A.D. County Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR				
JAN 26 1965		Robert E. Farley			Milton E. Elickson 1129 N. Caroline				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0913	
BIRTH NO. 65 0913				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Paige, William Durham				1/18/65 2:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1910 Cedric Ave.				A. STATE Maryland B. COUNTY 15-09	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 1910 Cedric Ave. Rd	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/11/1893	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk Va.
13. FATHER'S NAME William Durham			14. MOTHER'S MAIDEN NAME Addie Billups		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 165-03-6866		17. INFORMANT Bertha Durham ADDRESS 1910 Cedric Ave.
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema				24 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma Rectum				July 23 1964	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hab operation for Carcinoma of Breast 1952					
19A. DATE OF OPERATION Aug 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Rectum		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) July 17 1965		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 13 1964 to January 15 1965 , that (I) (was) last saw the deceased alive on Jan 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (not) view the body after death.					
23A. SIGNATURE Ralph J. Young				23B. DATE SIGNED 1/21 1965	
23C. PHYSICIAN'S NAME (Type) Ralph J. Young				23D. ADDRESS 1532 E Monument St Balto Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Qualtrick & Clark 1129 N. Carroll St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

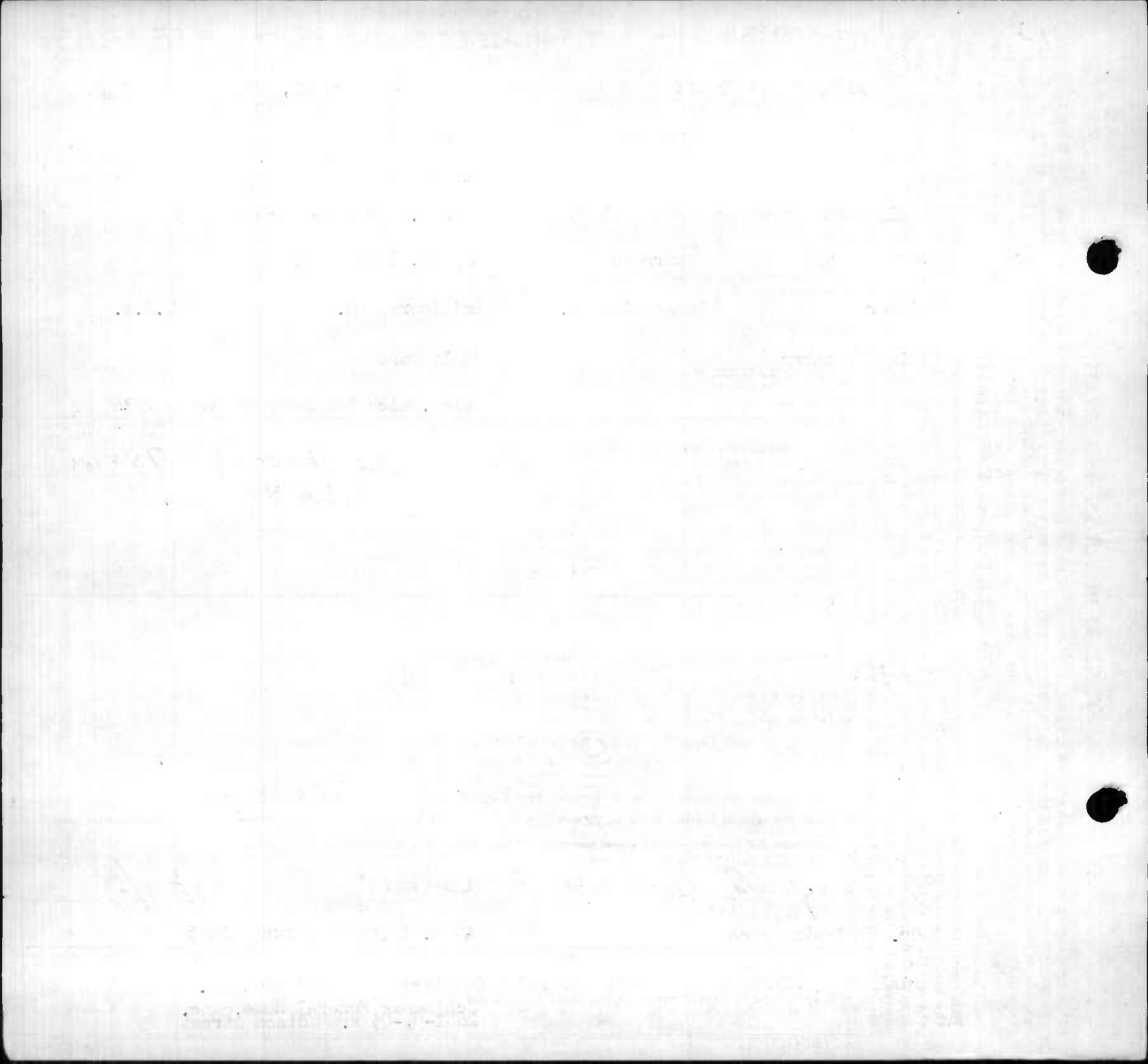
BIRTH NO. 63-29026 65 0914		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 0914 ✓	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>C. Heistinn</i>		2. DATE AND HOUR OF DEATH <i>11-18-65</i> <i>16</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>8-06</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>1637 N. Broadway</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 10-24-63	9. AGE (In years last birthday) 1 YR	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME BERNADETTE BOSTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>75431</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Atrial septal defect</i> DUE TO (B) <i>Pulmonary hypertension</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>11/14/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ASD</i>		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>12/1/65</i> 19 to <i>1/18</i> 1965, that the (we) last saw the deceased alive on <i>1/18/65</i> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) the (did) not view the body after death.					
23A. SIGNATURE <i>H.D. Agnew</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/19/65</i>	
23C. PHYSICIAN'S NAME (Type) H.D. AGNEW		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1/23/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>A.A. County Md</i>		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR <i>Robert E. Farland</i>	
25C. FUNERAL DIRECTOR <i>Spencer P. Erickson</i>		25D. ADDRESS <i>11297, Chestnut St</i>			

MEMORANDUM FOR THE DIRECTOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

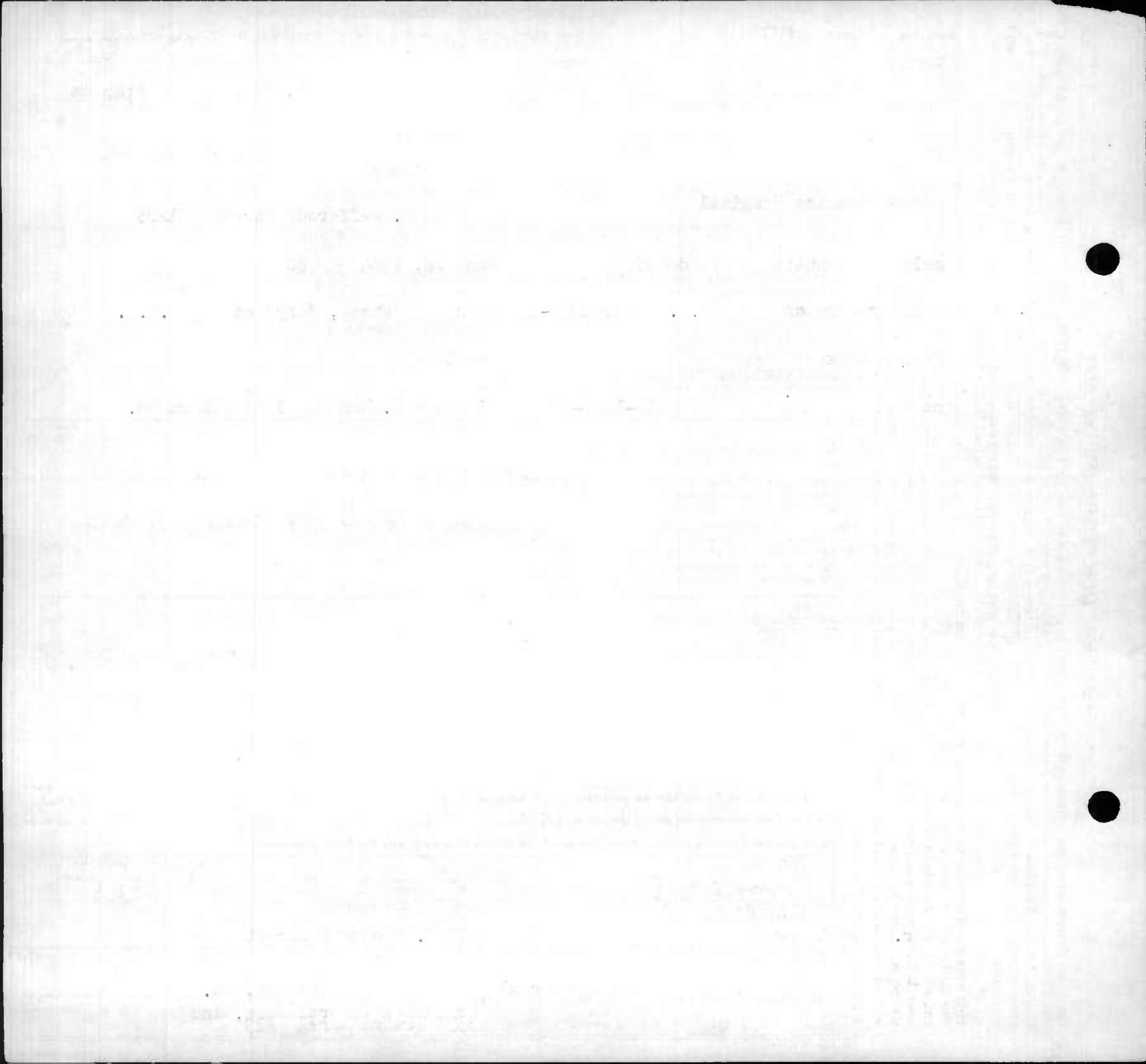
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0915	
BIRTH NO. 65 0915		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALICE VIOLA PRALEY		2. DATE AND HOUR OF DEATH January 22, 1965 3 am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 814 North Streeper Street 21205				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 814 N. Streeper Street 21205			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH may 18, 1904	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) finisher		10B. KIND OF BUSINESS OR INDUSTRY Gamse Lith Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Whitaker				14. MOTHER'S MAIDEN NAME Viola Barth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Helen Dolch 126 Lyndale Avenue #36			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUCINOMA - (LIVER) (PRIMARY)				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 01964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DIAGNOSTIC		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept. 1962 to JAN. 1965 , that (I) (we) last saw the deceased alive on JAN. 21 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Dr. Benjamin Moses				23B. DATE SIGNED 1/23/65		23C. PHYSICIAN'S NAME (Type) Dr. Benjamin Moses	
23D. ADDRESS 448 N. Luzerne Avenue 21205							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/65		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		25D. ADDRESS 2601-03-05 E. Madison Street #5	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0916		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0916	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ORVILLE B THOMAS				2. DATE AND HOUR OF DEATH January 24, 1965 8:45 am M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2710 E. Jefferson Street 21205			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH June 28, 1904	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Foreman		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government-Aberdeen		11. BIRTHPLACE (State or foreign country) Champ, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Thomas				14. MOTHER'S MAIDEN NAME Nettie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-1609-28		17. INFORMANT ADDRESS Florence N. Schulz 1621 Natura Rd.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				1A) DUE TO Coronary Occlusion 1 hour			
ANTECEDENT CAUSES				1B) DUE TO Anteriorly B-V-R. Disease 1 year			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				1C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 4 1959 to Jan. 18 1965, that (I) (we) last saw the deceased alive on Jan. 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23. SIGNATURE Dr. Israel Rosen M.D.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) Dr. Israel Rosen				23D. ADDRESS M.D. 2413 E. Monument Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc 3331 Brehms Lane #13		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 0917		CERTIFICATE OF DEATH		Registered No. 65 0917	
M.E. CASE NO. 65 0917		1. NAME OF DECEASED (Type or Print) Agnes Marie Alley		2. DATE AND HOUR OF DEATH Jan. 24, 1965 8:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5009 Elmer Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-18			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore,			
		D. STREET ADDRESS (If rural, give location) 5009 Elmer Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 7, 1901	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Clothing Cleaner		11. BIRTHPLACE (State or foreign country) Anderson, Indiana	
13. FATHER'S NAME James Soales			14. MOTHER'S MAIDEN NAME Frances Robinson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-28-5371		17. INFORMANT ADDRESS Mr. John E. Alley, 5009 Elmer Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Cardiac Failure Cardiovascular Renal Disease CA of Lung & Metastases		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 hr 1 hr	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/19/65 to 1/24/65 that (I) (we) last saw the deceased alive on 1/24/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph G. Laukaitis M.D. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) Joseph G. Laukaitis, M.D.				23D. ADDRESS 679 Washington Blvd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME OF CEMETERY OR CREMATORY East Maplewood Cemetery	
24D. LOCATION Anderson, Indiana		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1965			
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. FUNERAL DIRECTOR Vernon Lemmon		24H. ADDRESS 4611 Park Heights Ave.	

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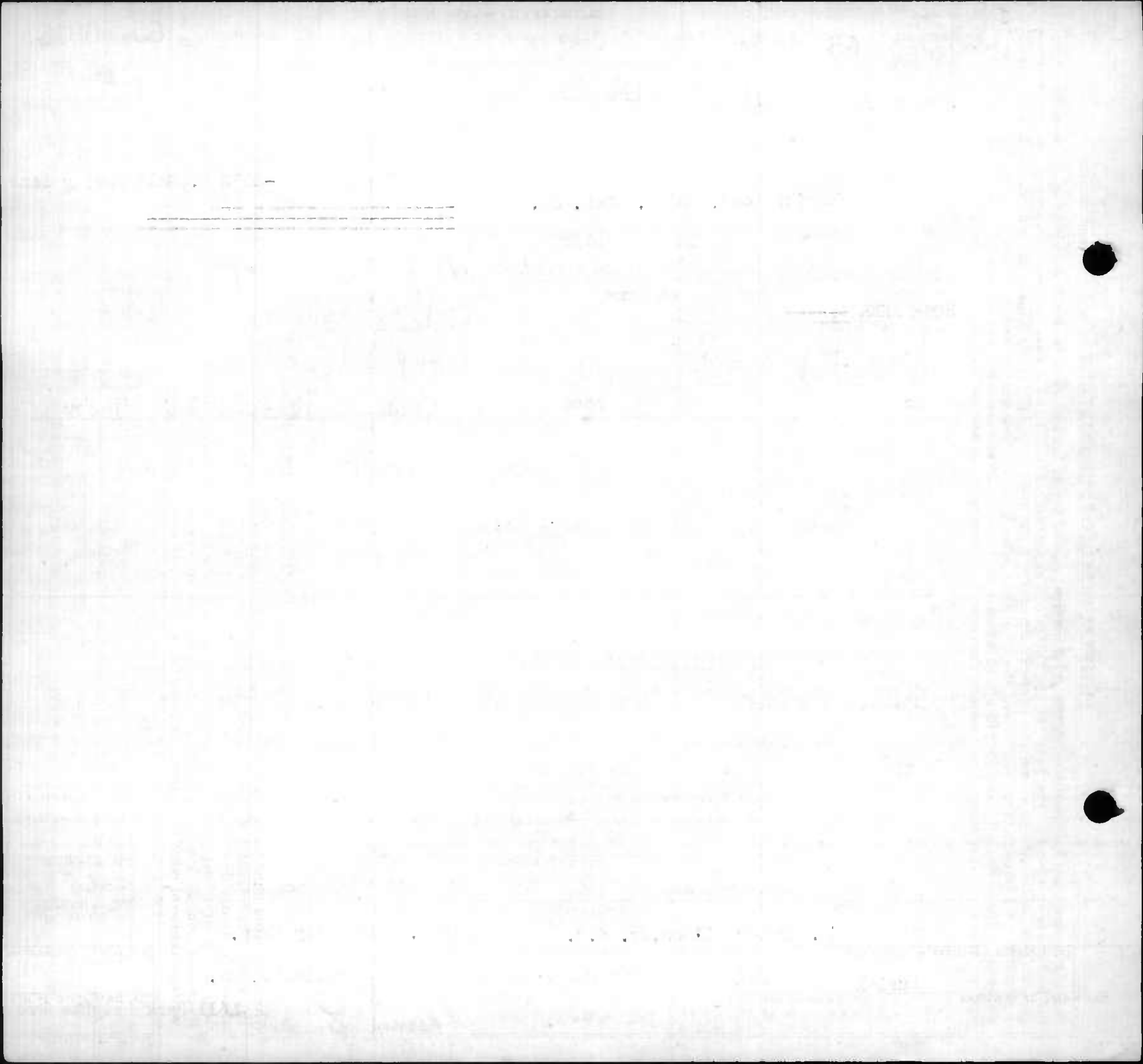
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0918	
BIRTH NO. 65 0918		M.E. CASE NO. 65 0918		1. NAME OF DECEASED (Type or Print) Jamison, Miss Elsie		2. DATE AND HOUR OF DEATH JAN. 23, 1965 8²⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Keswick Home, 700 W. 40th. St.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2632 W. Cold Spring Lane 700 W. 40th St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 7/31/1888	9. AGE (In years last birthday) 76 yrs	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER None		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Jamison				14. MOTHER'S MAIDEN NAME MARY L. Wortche			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Grace S. McFaul RN		ADDRESS 700 W 40th	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible pulmonary embolism				CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Chronic Heart Disease DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 18, 1961 to Jan. 23, 1964 , that (I) (we) last saw the deceased alive on 1-23-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Hunter Wilson Jr. M.D.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr. M.D.				23D. ADDRESS 505 W. University Pkwy.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/65		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Lemon Lemmon		ADDRESS 4611 Park Heights Ave	



BIRTH NO. 65 0919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0919

M.E. CASE NO. 59395

1. NAME OF DECEASED (Type or Print) HAROLD PETTUS				2. DATE AND HOUR PRONOUNCED DEAD January 24, 1965 8:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glen Burnie 52-00 D. STREET ADDRESS (If rural, give location) 1111 Dorsey Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 10-3-1915	9. AGE (In years last birthday) 49	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOWER		10B. KIND OF BUSINESS OR INDUSTRY FRIENDSHIP AIRPORT		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HAROLD A. PETTUS				14. MOTHER'S MAIDEN NAME EDNA D. HUGHES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mary E. Logan Bellport L.I. Ny.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral Hemothorax ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Laceration of Heart. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rt. 176, W. of Elkridge Landing, A.A.Co.			
21D. TIME OF INJURY (APPROX.) 1 24 '65 A.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver in auto-auto collision.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/24/65							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 1-29-1965		23C. NAME of CEMETERY or CREMATORY GREENWOOD CEMETERY BROOKLYN		23D. LOCATION (City, town, or county) (State) N.Y.	
24A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR Weber Funeral Home		ADDRESS 5311 Edmondson Ave	

Class 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0920

BIRTH NO. 65 0920

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Roger Lambert

2. DATE AND HOUR OF DEATH

1/22/65 8 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

MARYland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md Carroll

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Westminster 56-27

D. STREET ADDRESS (If rural, give location)

27 E. MAIN ST

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

11/25/07

9. AGE (In years last birthday)

57

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR INDUSTRY

Martin Marietta

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Herbert Lambert

14. MOTHER'S MAIDEN NAME

Annie Cramer

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

217-07-5985

17. INFORMANT

Self

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Metastatic Ca of lung

(B) DUE TO

(C) DUE TO

2 1/2 months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/6 1964 to 1/22 1965, that (I) (we) last saw the deceased alive on 1/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. M. Byers

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/22/65

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION, REMOVAL (Specify)

burial

24B. DATE

1/25/65

24C. NAME of CEMETERY or CREMATORY

Church of God Cemetery

24D. LOCATION

(City, town, or county)

(State)

Uniontown, Carroll, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1965

25B. NAME OF REGISTRAR

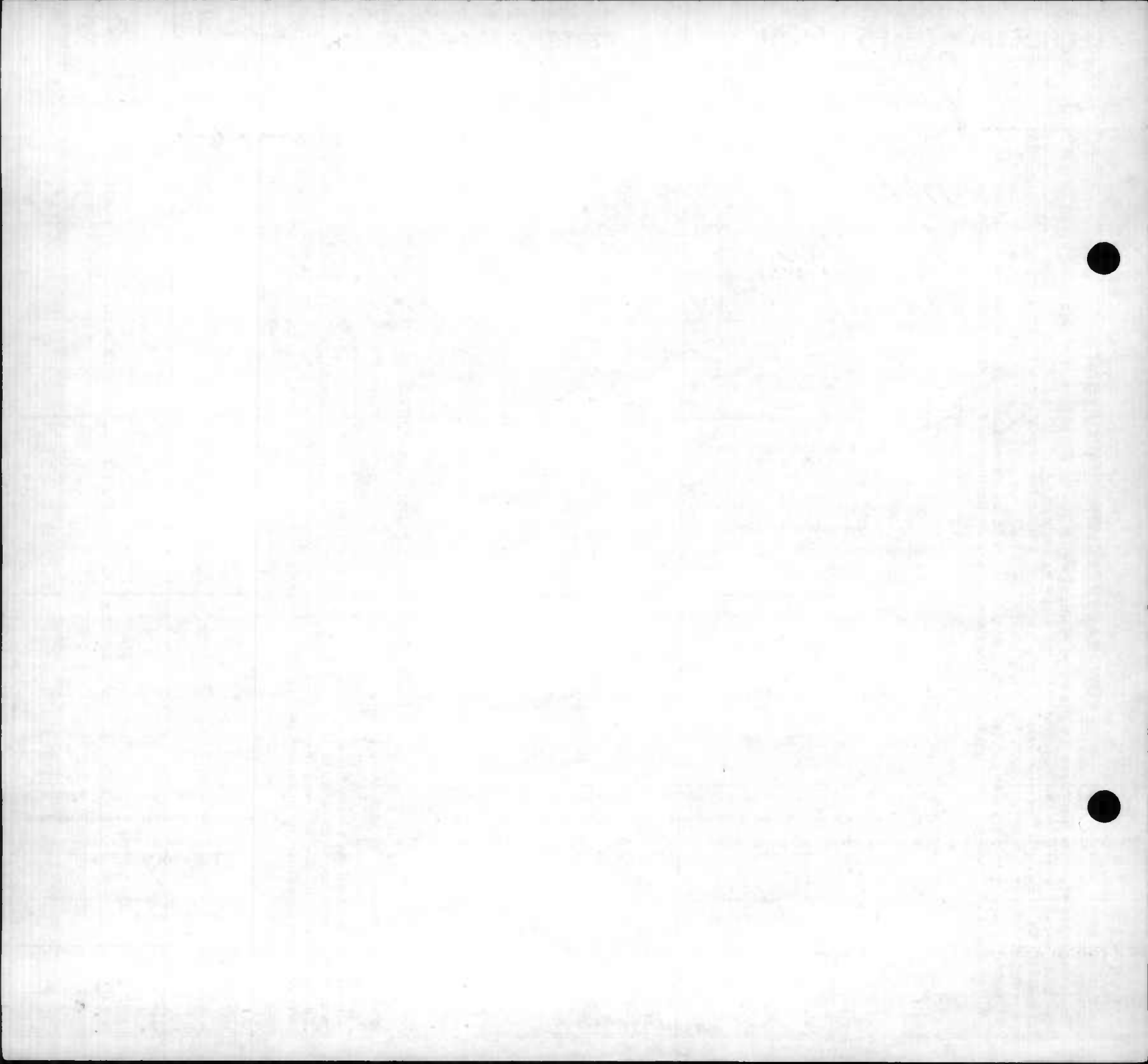
Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

J. E. Myers, Jr.

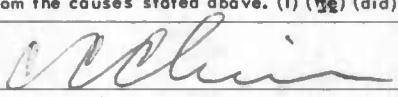
ADDRESS

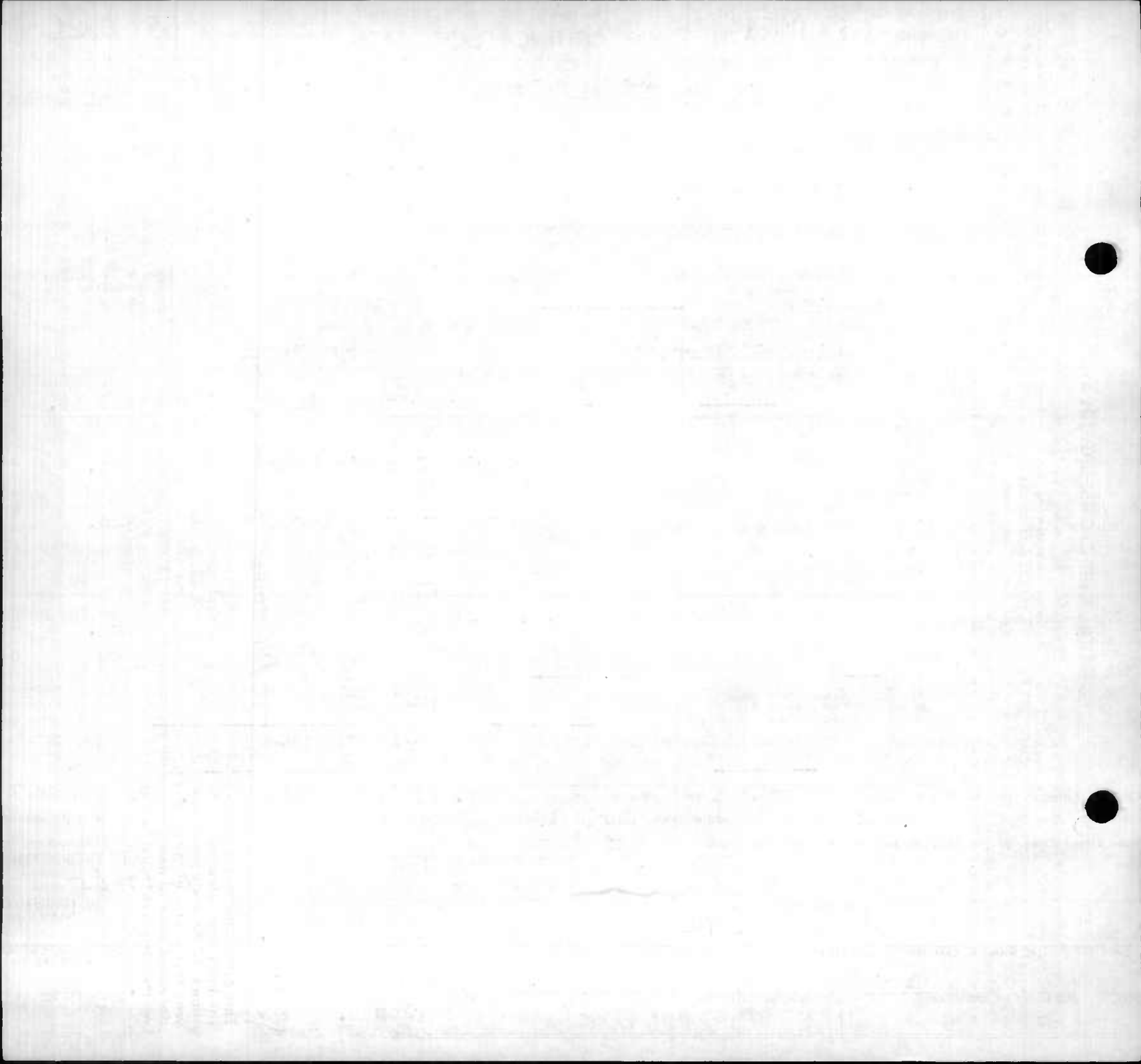
91-95 Willis St. Westminster, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

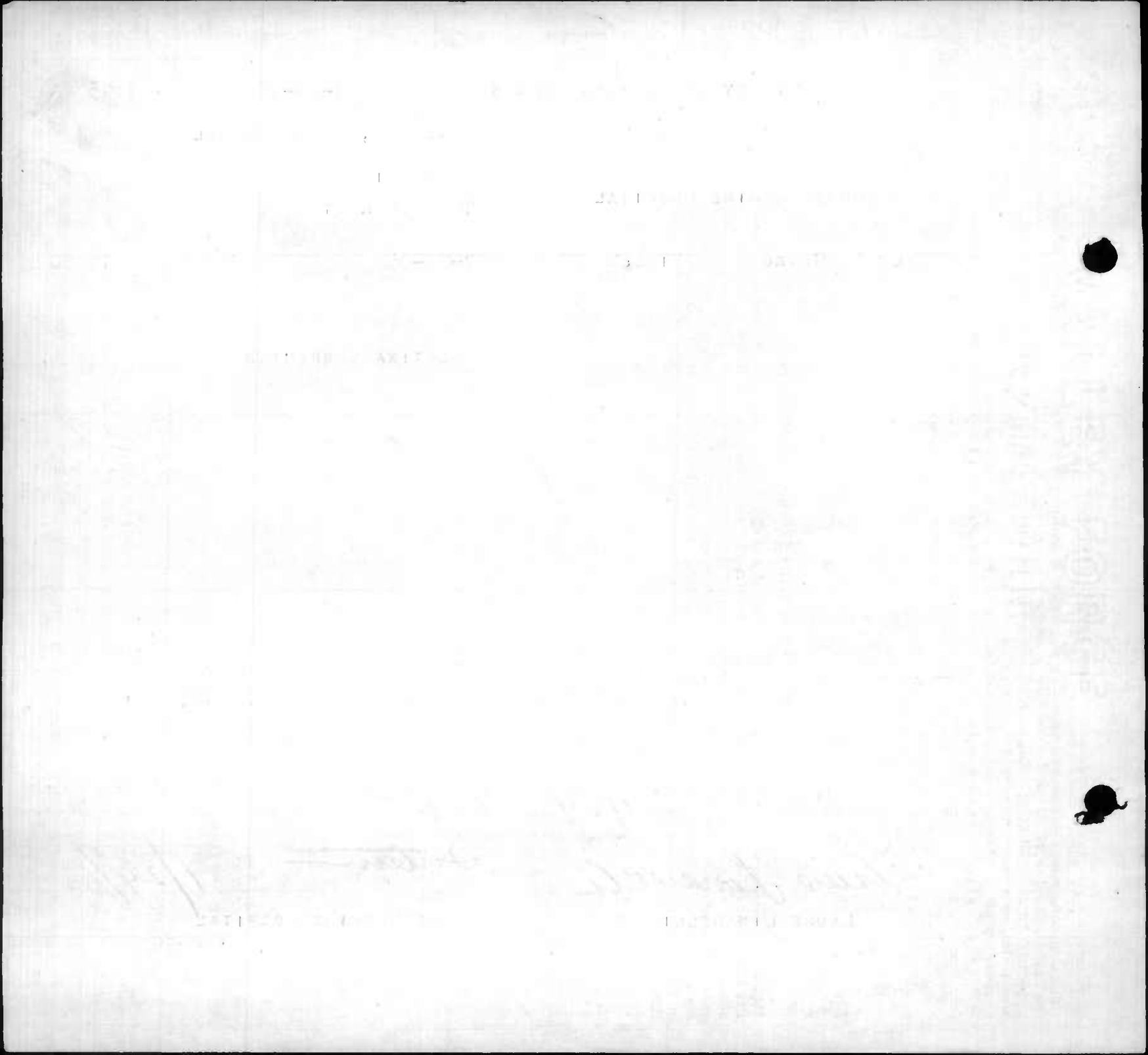
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0921	
BIRTH NO. 65 0921		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Nora Katherine Coleman		2. DATE AND HOUR OF DEATH January 22, 1965 1:30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1301 Haubert St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1301 Haubert St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/8/1874	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME Michael Barrett				14. MOTHER'S MAIDEN NAME Mary Flynn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Margaret Koesters 1301 Haubert St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 2 yrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. General arteriosclerosis yrs. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Nutritional Anemia yrs.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -----			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -----		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -----			
22. I certify that (I) (the physician) attended the deceased from Nov. 24 19 64 to Jan. 22 19 65 , that (I) (we) last saw the deceased alive on Jan. 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.							
23A. SIGNATURE  M.D. C. C. CHIU				23B. DATE SIGNED 1-23-65		23C. PHYSICIAN'S NAME (Type) C. C. CHIU	
23D. ADDRESS M.D. 1 E. Randall St.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Charles L. Stevens Funeral Home, Inc. 1501 E. Forest Avenue			



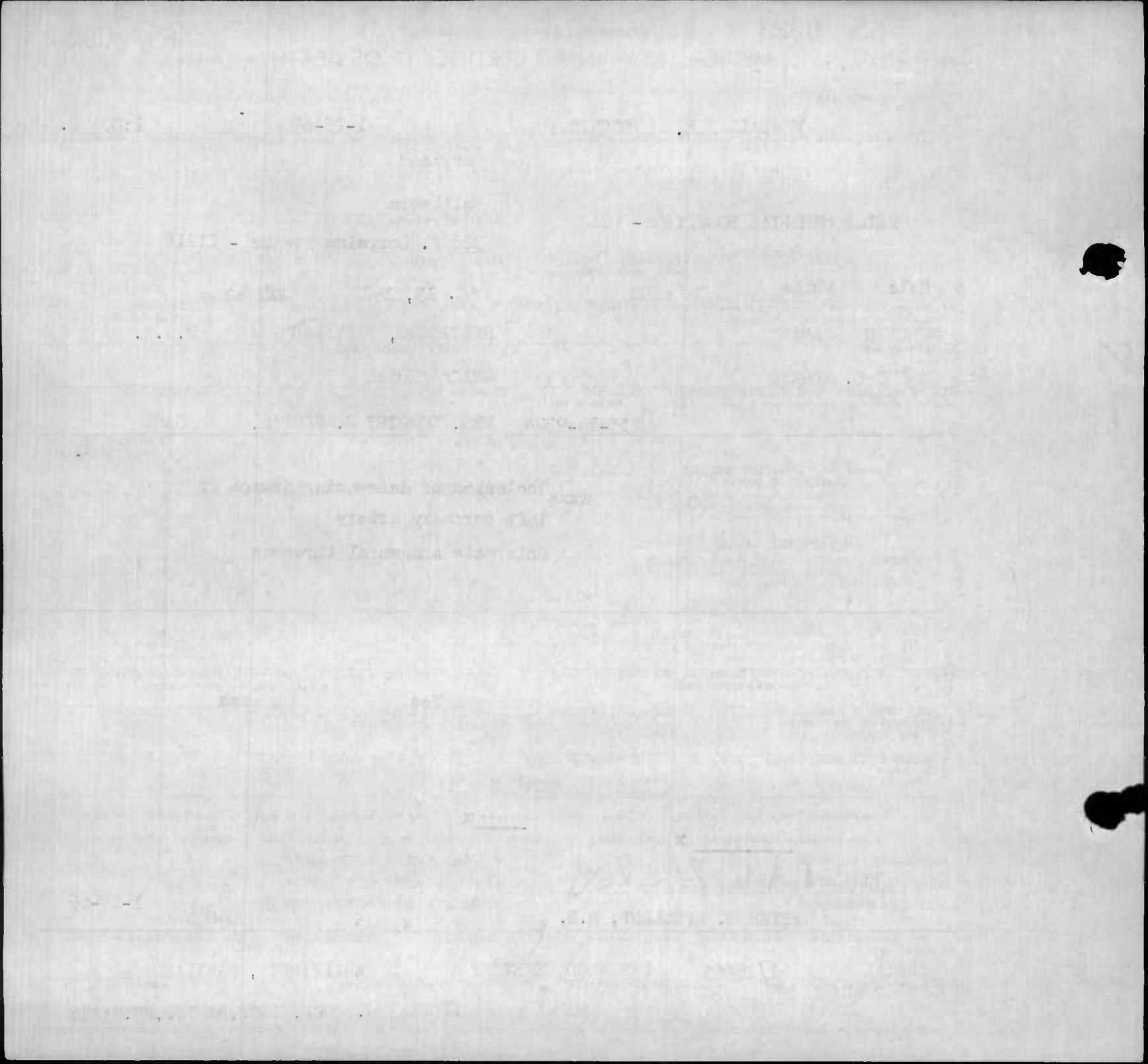
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0922	
BIRTH NO. 65-02193		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BABY BOY OF BERTINA COATES		1-24-65 11:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
JOHNS HOPKINS HOSPITAL		MARYLAND, ANNE ARUNDEL			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		ANNAPOLIS			
		D. STREET ADDRESS (If rural, give location)			
		104 SOUTH ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	NEGRO	SINGLE	1-23-65		18 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
			BERTINA CARPENTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Prematurity		19 hrs	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/23/65 to 1/24/65, that (I) (we) last saw the deceased alive on 1/24/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
LAURE LINARELLI				1/24/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LAURE LINARELLI		JOHNS HOPKINS HOSPITAL			
24A. BURIAL OR CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
		1/24/65		Johns Hopkins Hospital	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1965		Robert E. Farley, M.D.			



65 0923		BALTIMORE CITY HEALTH DEPARTMENT		65 0923	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO. 59405					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
WENDALL E. NORRIS			1-25-65 1:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL - DOA			A. STATE Maryland		
			B. COUNTY		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
			Baltimore 12-03 326 E. Lorraine Avenue - 21218		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH DEC. 13, 1922	9. AGE (In years last birthday) 42	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME EGBERT C. NORRIS		14. MOTHER'S MAIDEN NAME GRACE ERDMAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-14-9374	17. INFORMANT ADDRESS MRS. DOROTHY J. NORRIS, SAME		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Occlusion of descending branch of left coronary artery Sclerosis and mural thrombus DUE TO					
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE PETER W. RIECKERT, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-25-65	
		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
BURIAL		1/28/65		PARKWOOD CEMETERY	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1965		Robert E. Farley, M.D.		LEONARD J. RUCK, INC., BALTO., MD. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0924	
BIRTH NO. 65 0924		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Tagliabue, Marie E</i>		2. DATE AND HOUR OF DEATH <i>1-25-65 6:15 PM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<div style="border: 1px solid black; padding: 2px;"> CERTIFICATE CORRECTED 2-1-65 <small>Full name of deceased, if not in hospital, or institution, give street address or location</small> </div>		A. STATE <i>md</i>		B. COUNTY <i>27-03</i>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
D. STREET ADDRESS (If rural, give location) <i>2812 Goodwood Rd</i>					
5. SEX <i>F</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1900 6-22-99</i>	9. AGE (In years last birthday) <i>65-64</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>MARTIN BORINSKY</i>		14. MOTHER'S MARDEN NAME <i>NOT KNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>MR. STEPHEN C. TAGLIABUE</i>		ADDRESS <i>SAME</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Cerebral Thrombosis</i>			
		(B) <i>DIABETES MELLITUS</i>			
		(C) <i>GENERALIZED ARTERIO-SCLEROSIS</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-19-1965</i> to <i>1-25-1965</i> , that (I) (we) lost saw the deceased olive on <i>1-25-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ephraim Barzaga</i> M.D.				23B. DATE SIGNED <i>1-25-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ephraim B. BARZAGA</i> M.D.				23D. ADDRESS <i>CHURCH Home & Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/28/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>LAKEVIEW MEMORIAL CEMETERY</i>	
				24D. LOCATION (City, town, or county) (State) <i>CARROLL COUNTY, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>LEONARD J. RUCK, INC., BALTO., MD</i>	

65 0925

BALTIMORE CITY HEALTH DEPARTMENT

65 0925

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDITH COATES

2. DATE AND HOUR PRONOUNCED DEAD

1/22/65 10:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)N.
1365 Stockton St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
MarylandB. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1365 N. Stockton St.

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

female colored

3-17-1879 85

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

La Plata md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Wills

14. MOTHER'S MAIDEN NAME

Rosenna Wills

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Harris Reed - 1822 Division St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

W.H. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

1/22/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1965

Robert E. Fisher, M.D.

Rumell B. Oden - Balto. md.

WILLIAM L. HARRIS

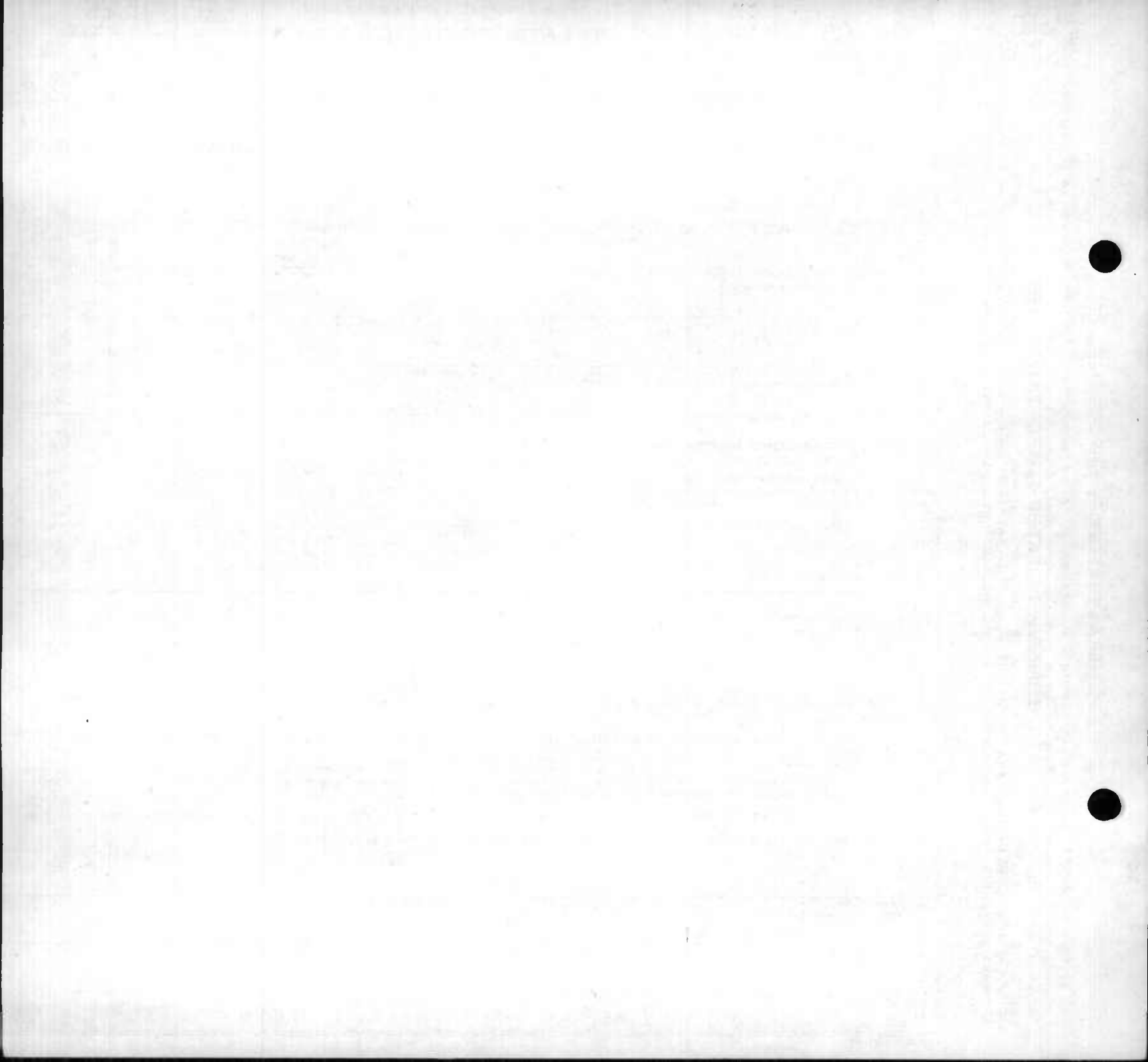
WILLIAM L. HARRIS

WILLIAM L. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

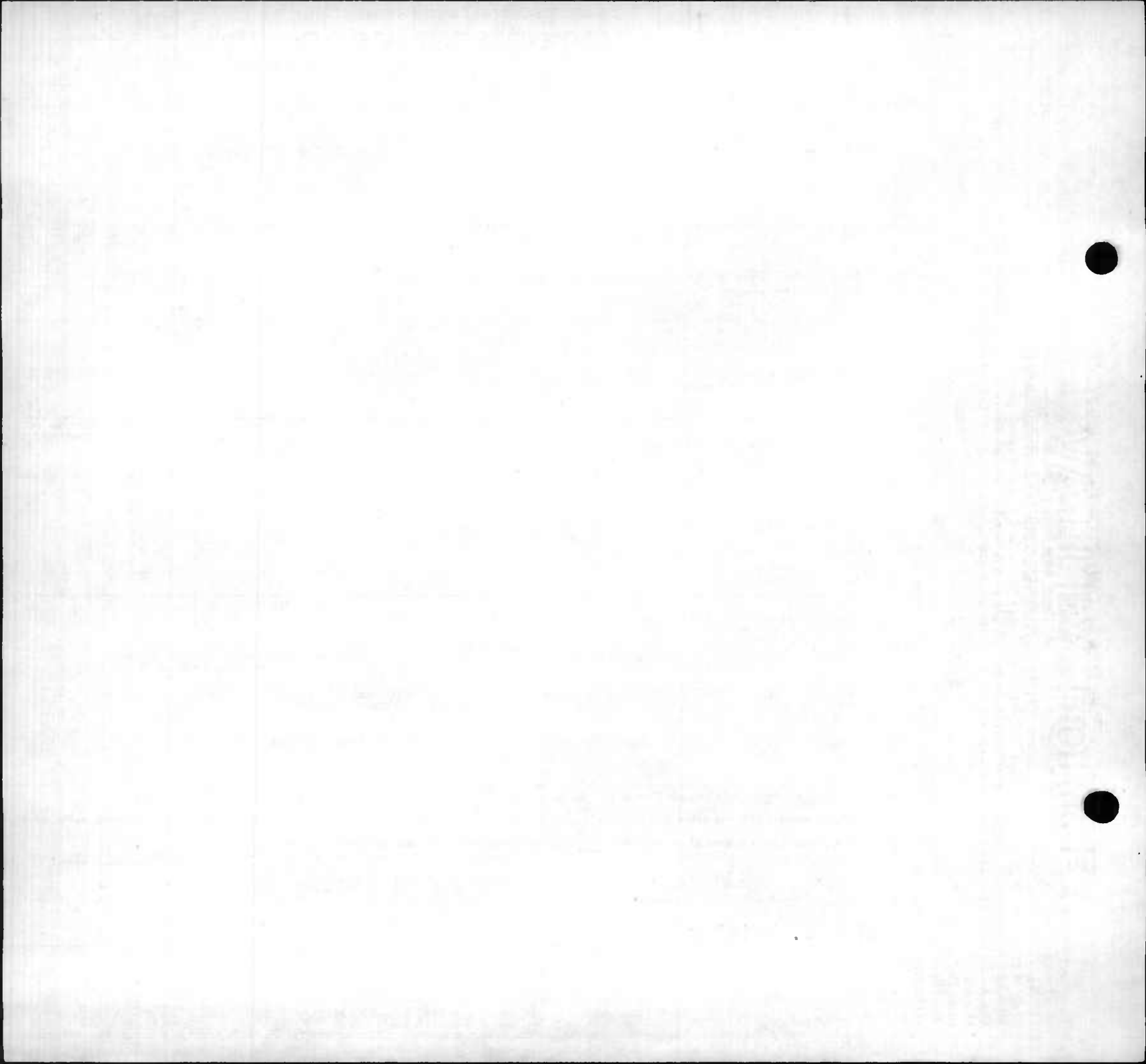
BIRTH NO. 65 0926		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0926	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY GIRL DARGY		2. DATE AND HOUR OF DEATH 1-12-1965 2:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		A. STATE MD B. COUNTY 13-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 1908 PARK AVE #17			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1-10-65	9. AGE (In years last birthday) —	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Joseph DARGY		14. MOTHER'S MAIDEN NAME CHARITY MOORE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MOTHER		ADDRESS 1908 PARK AVE #17 MD
18. 776X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) PREMATURITY		2 DAYS	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-10-65 to 1-12-65 , that (I) (we) lost saw the deceased alive on 1-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carlos Abel		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-12-65	
23C. PHYSICIAN'S NAME (Type) Carlos Abel		23D. ADDRESS ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) JAN 26 1965		24B. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Finkley, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

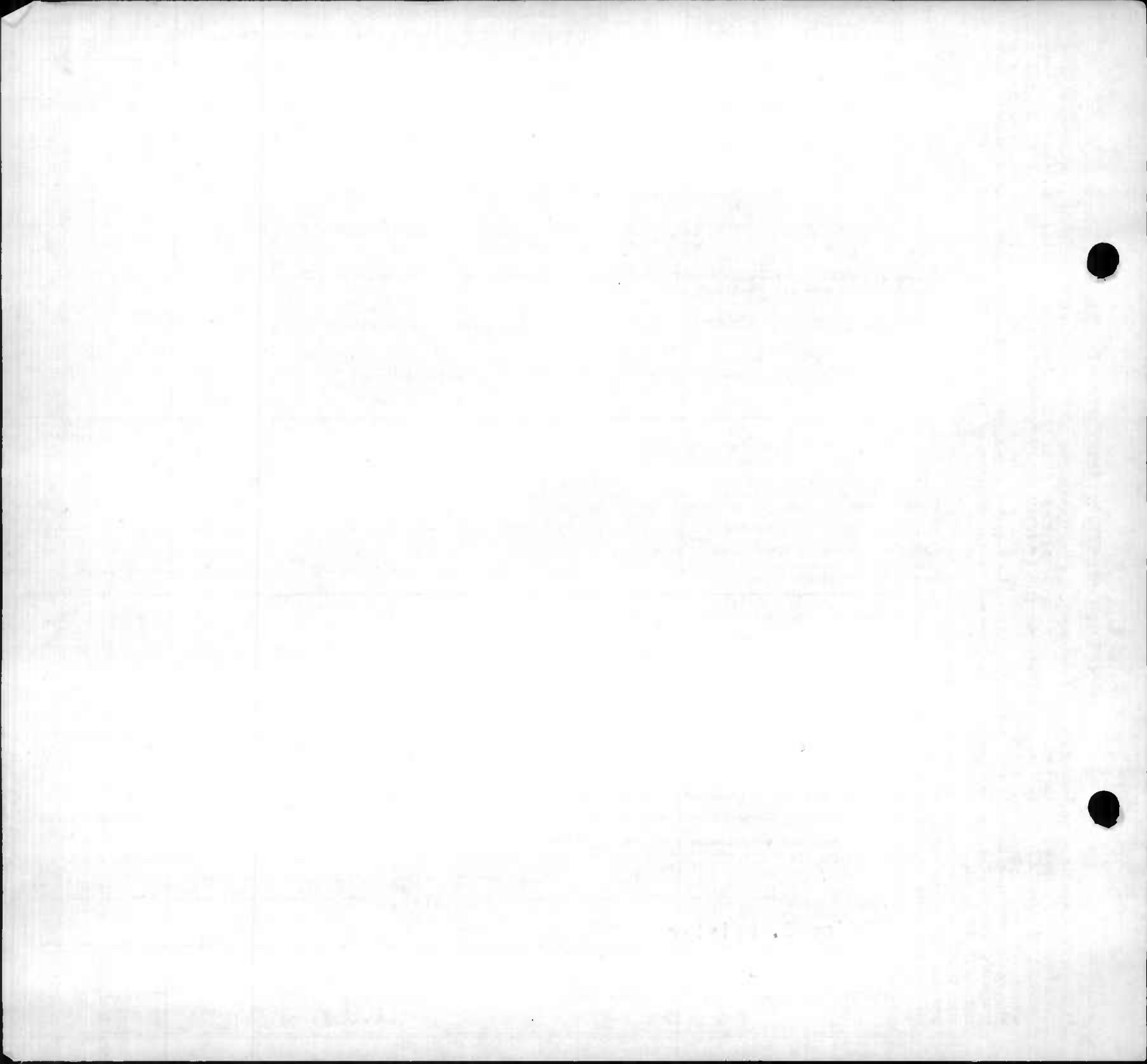
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0927</u>	
BIRTH NO. <u>65 0927</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY CANNON</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH <u>JAN. 20, 1965</u> <u>8¹⁰ P.</u> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>UNIVERSITY HOSPITAL</u> B. COUNTY <u>BALTIMORE, MD.</u>			
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>1/20/65</u>	
13. FATHER'S NAME <u>Clarence Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Jones</u>		9. AGE (In years last birthday) <u>18</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
17. INFORMANT <u>University Hospital</u>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. <u>773.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Distress Syndrome</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <u>Prematurity</u>		<u>18 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
(C) DUE TO					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 20, 1965</u> to <u>JAN. 20, 1965</u> , that (I) (we) last saw the deceased alive on <u>JAN. 20, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alice B. Heisler</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>JAN. 21, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alice B. Heisler</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> <u>ANATOMY BOARD OF MARYLAND</u> <u>JOHNS HOPKINS MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>JAN 26 1965</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

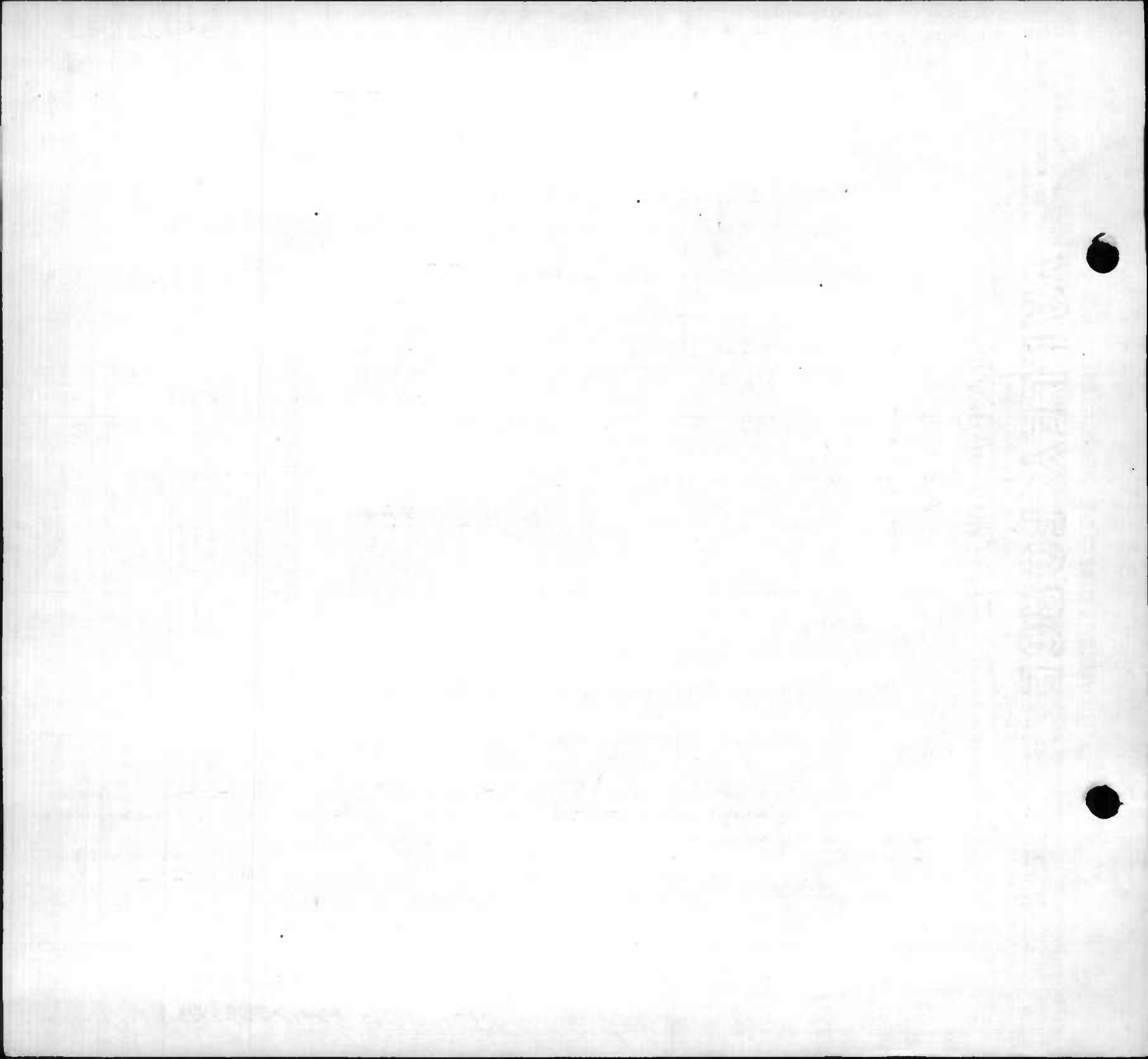
BIRTH NO. 65 0928		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0928	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BABY GIRL JOHNSON			2. DATE AND HOUR OF DEATH 1/13/65 7:58 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 13-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 922 Newington Ave # 17		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 1/12/65	9. AGE (In years last birthday) 9
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHNIE JOHNSON			14. MOTHER'S MAIDEN NAME EUGENIA WILSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS UNIVERSITY HOSPITAL	
18. 176X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Immaturity ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 9 hrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN. 12 1965 to JAN. 13 1965 , that (I) (we) lost saw the deceased alive on JAN. 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alice B. Heisler M.D.				23B. DATE SIGNED JAN. 13, 1965	
23C. PHYSICIAN'S NAME (Type) Alice B. Heisler		23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify) JAN 26 1965		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

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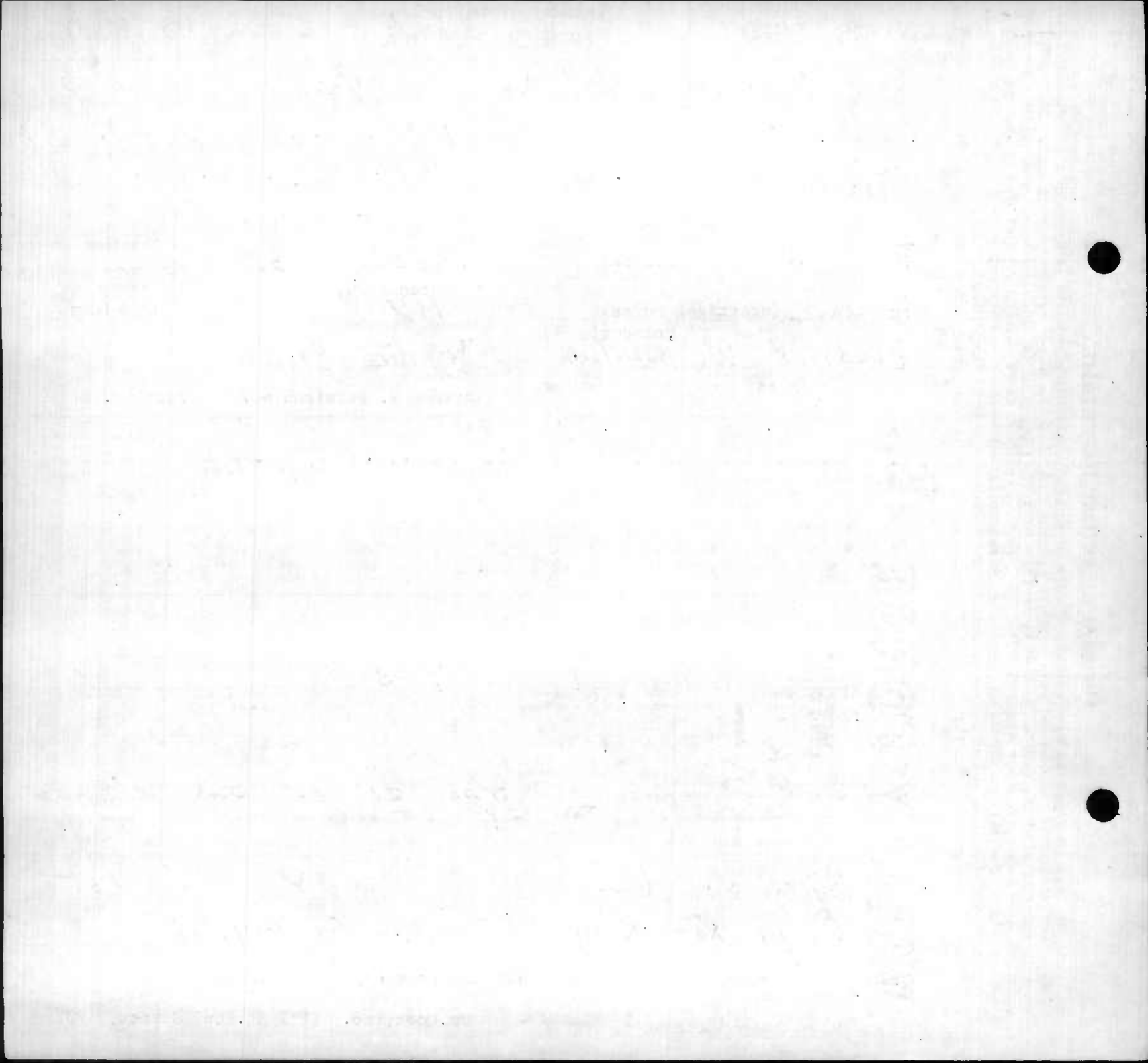
BIRTH NO. 65 0929		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0929	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Summerville, James Andrew		1-24-65 8:00 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division St. Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY 14-22			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Baltimore		531 Laurens St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Negro		12-4-64	1 Month	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Archie Summerville		Rosa Ann Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				(Mother) Rosa Ann Summerville 531 Laurens	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Dehydration DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Gastroenteritis DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pneumonitis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-24-65 19 to 1-24-65 19, that (I) (we) lost saw the deceased alive on 1-24-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
M. Behrooz				1-25-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Behrooz		M.D. 1514 Division St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/26/65		MT CALVARY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1965		Robert E. Finkbeiner		George C. G. Kelson 1348 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0930	
BIRTH NO. 65 0930							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)		Harrison Ethel V.				2. DATE AND HOUR OF DEATH 1/22/65 10⁴⁰ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY 27-11	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		21212	
				D. STREET ADDRESS (If rural, give location) 407 Woodford Rd			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 11/4/01	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (practical Nurse)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Queenstown, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fredrick W. Metzdorf		13. FATHER'S NAME Metzdorf		14. MOTHER'S MAIDEN NAME Jennie Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Clarence W. Harrison, 407 Woodford Rd., 21212			
18. 420.1 I		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Myocardial Infarction					
ANTECEDENT CAUSES		(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN. 21 1965 to JAN 22 1965 , that (I) (we) last saw the deceased alive on JAN. 22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Byong Koo Kim		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/22/65			
23C. PHYSICIAN'S NAME (Type) Byong Koo Kim		M.D.		23D. ADDRESS Franklin Sq Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.A.		25C. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, 21202		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 0931					REGISTERED No. 65 0931					
CERTIFICATE OF DEATH										
1. NAME OF DECEASED (Type or Print) KWEDAR, ELIZABETH					2. DATE AND HOUR OF DEATH 1-22-65 2:00A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-31 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 D. STREET ADDRESS (If rural, give location) 312 MARYDELL ROAD					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-19-97	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE SEAMSTRESS - TAILORING			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MICHAEL MARTIN					14. MOTHER'S MAIDEN NAME NOT KNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVES					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none					(A) Cerebral hemorrhage DUE TO (B) Hypertensive Cardiovascular Dis DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH 72 hrs 3 years
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 18 19 65 to JANUARY 22 19 65, that (I) (we) last saw the deceased alive on JANUARY 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Marston A. Young					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED Jan. 22, 1965		
23C. PHYSICIAN'S NAME (Type) MARSTON A. YOUNG					23D. ADDRESS M.D. ST. AGNES HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-65		24C. NAME OF CEMETERY or CREMATORY Landon Park Cem.			24D. LOCATION (City, town, or county) (State) Baltimore Ind.			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965			25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR ADDRESS Farley Funeral Home - Catonsville, Md.				

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 0932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0932M.E. CASE NO. 59391

1. NAME OF DECEASED (Type or Print) HENRY BEIGEL				2. DATE AND HOUR PRONOUNCED DEAD January 23, 1965 9:40 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2601 D. STREET ADDRESS (If rural, give location) 4305 Anntanna Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH January 1, 1887	9. AGE (In years last birthday) 78	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cooper			10B. KIND OF BUSINESS OR INDUSTRY Meat Packers		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Paul Beigel			14. MOTHER'S MAIDEN NAME Minnie Dean				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 1		16. SOCIAL SECURITY NO. 213-01-3391	17. INFORMANT Son Mr. Irvin H. Beigel 4305 Anntana AVE - 6				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Petty</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/24/65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/27/1965	23C. NAME OF CEMETERY Baltimore National		23D. LOCATION (City, town, or county) (State) Balto., Md.		
24A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 Belair Rd.	

VALLEY PHOTO

LS: 12-31-22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 0933

BIRTH NO. 65 0933

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Harry Clark

2. DATE AND HOUR OF DEATH

January 26, 1965

5:30

A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hosptials
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 Eastern Avenue #21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

2-9-1886

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Jacob Clark

14. MOTHER'S MAIDEN NAME

Georgianna Hamilton

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

219-01-1545

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Generalized Arteriosclerosis
DUE TO Years(B) Cerebral Vascular Accident
DUE TO Years(C) Broncho-Pneumonia
DUE TO 1 Week

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Chronic Urinary Tract Infection

Years

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 20, 19 48 to January 26, 19 65,
that (I) (we) last saw the deceased alive on January 26, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Julius Krevans

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

January 26, 1965

23C. PHYSICIAN'S
NAME (Type)

Julius K. Krevans

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan-28-1965 Parkwood

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Taylor Ave. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1965

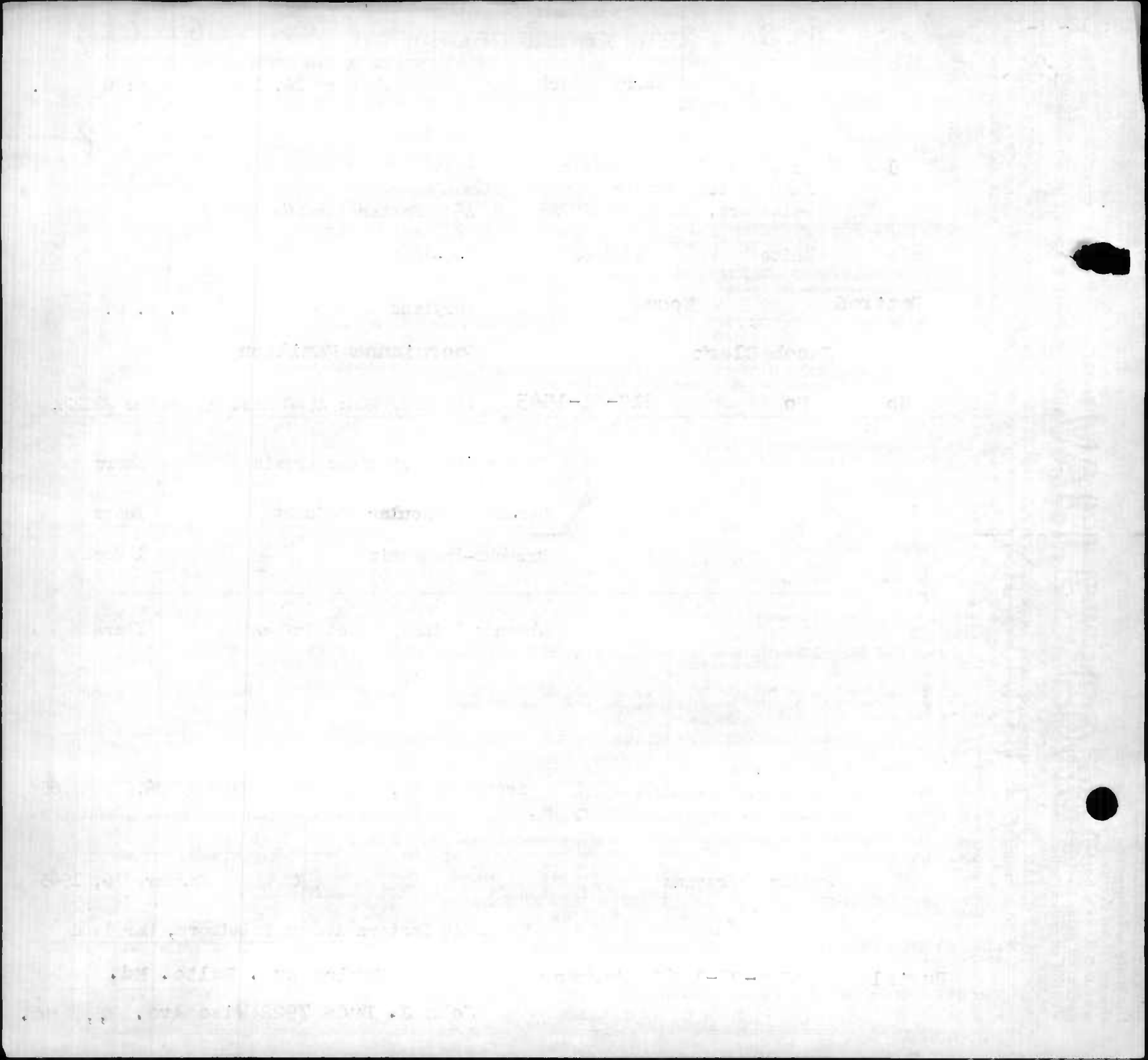
25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

ADDRESS

John J. Duda 7922 Wise Ave. 22, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0934				
BIRTH NO. 65 0934 M.E. CASE NO.					2. DATE AND HOUR OF DEATH JAN. 26, 1965 6:05 AM.				
1. NAME OF DECEASED (Type or Print) WILLIAM SOMMERS					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTO.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE				
					D. STREET ADDRESS (If rural, give location) 224 CARROLL ROAD				
5. SEX MALE		6. RACE CAUC.		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2/22/06		9. AGE (In years last birthday) 58 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec. Plater					10B. KIND OF BUSINESS OR INDUSTRY Bendit			11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Helen Sommers (Same as above)		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, atherio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH 1/26/65 - 1/26/65	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1965 to JAN 26 1965 , that (I) (we) last saw the deceased alive on JAN 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jerome Paul Reichmister					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/26/65	
23C. PHYSICIAN'S NAME (Type) JEROME PAUL REICHMISTER					23D. ADDRESS SINAI HOSPITAL OF BALTIMORE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME OF CEMETERY or CREMATORY Landon Park			24D. LOCATION (City, town, or county) (State) Ind. Rd. Balt. Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR ADDRESS John J. Carmon, Jr. Inc. 9017 Fallers Ct. Balt. Md.				

1940

WINTER HARBOR - 1940

WINTER HARBOR - 1940

WINTER HARBOR - 1940

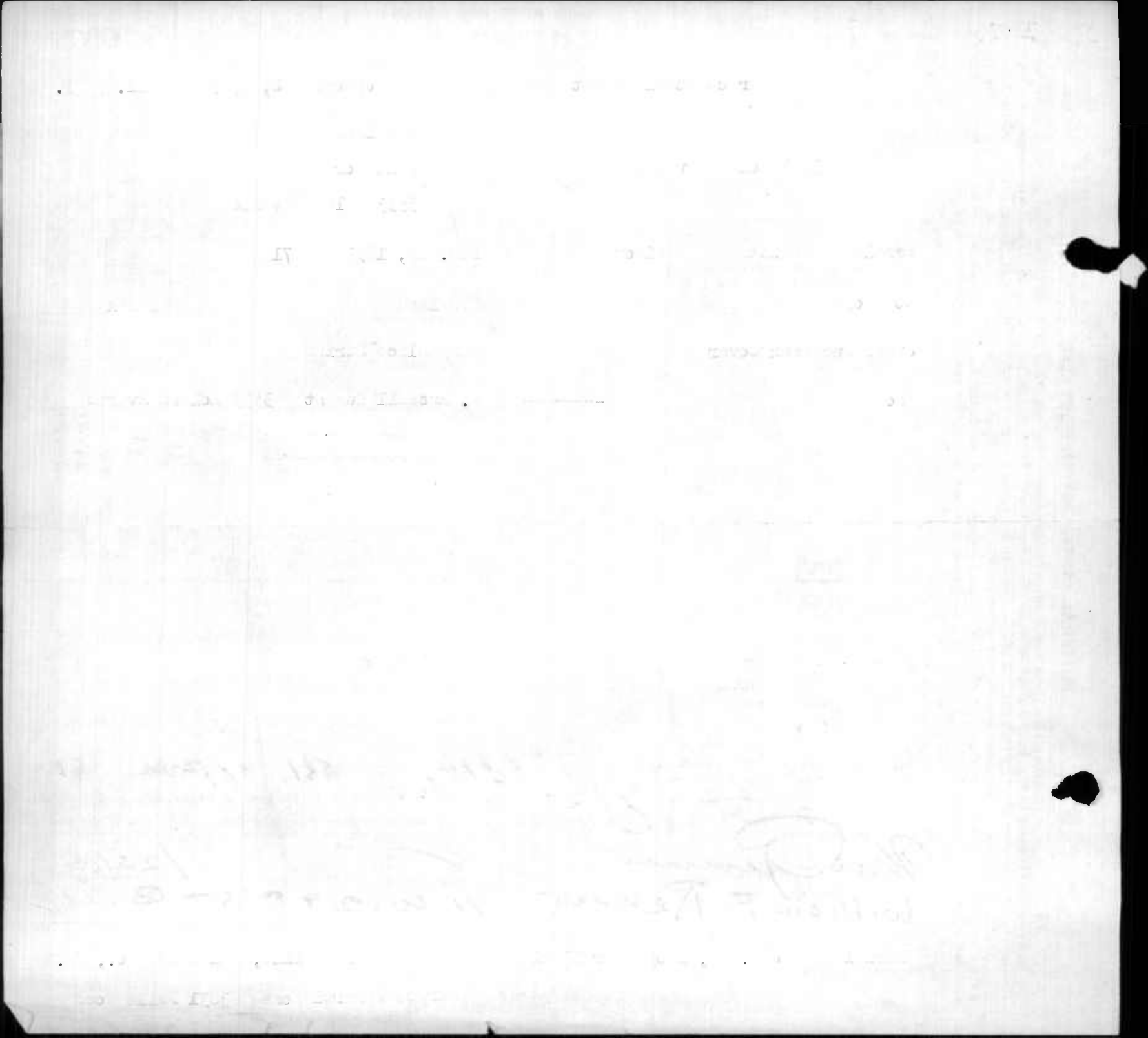
WINTER HARBOR - 1940

WINTER HARBOR - 1940

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0935					Registered No. 65 0935				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) Grace Ethel Dugent					January 22, 1965 11.45 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3533 Roland Avenue					A. STATE B. COUNTY Maryland 1306				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3533 Roland Avenue				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Feb. 22, 1893	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Buchanan Cover					14. MOTHER'S MAIDEN NAME Mary Alice Strine				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -----		17. INFORMANT W. Russell Dugent			ADDRESS 3533 Roland Avenue	
18. 153.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) concomitant of the cancer					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH 3 mos				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION Nov. 164			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca of cancer			20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/14 1951 to 1/22 1965, that (I) (we) last saw the deceased alive on 6/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William F. Renner					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) William F. Renner					23D. ADDRESS 11 W. 29th St Baltimore				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Jan. 26, 1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Baltimore Co., Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Burgess Funeral Home			
						ADDRESS 3631 Falls Road			



F. 630

64-28982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0936

BIRTH NO. 65 0936

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN Douglas FORD

2. DATE AND HOUR OF DEATH

1-24-65 12:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

27-15

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2210 Ken Oak Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Infant

8. DATE OF BIRTH

Oct. 20-1964

9. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3 4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland (Prison) U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles E. Ford Jr.

14. MOTHER'S MAIDEN NAME

Terese Trivison

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

—

16. SOCIAL
SECURITY NO.

17. INFORMANT

Charles E. Ford Jr. 2210 Ken Oak Road

ADDRESS

18. 751.2 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, oshtenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

brain increased intracranial
pressure

(B) DUE TO

congenital hydrocephalus
ruptured meningocystic

(C)

INTERVAL BETWEEN
ONSET AND DEATH

2 days

since birth

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1/22/65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

ruptured meningocystic

20A. AUTOPSY? (Yes or No)

NO.

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)☐21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 22 1965 to Jan 24 1965,
that (I) (we) last saw the deceased alive on Jan 24 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Imelda B. Salanio

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/24/65

23C. PHYSICIAN'S
NAME (Type)

Imelda B. Salanio

M.D.

23D. ADDRESS

Mercy Hospital Balt. Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

Burial Jan 27-1965 Lake View

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Cleveland, Ohio

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1965

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Burger Funeral Home 3631 Park Road

ADDRESS

Horace P. Burger

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1
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65 0937

BALTIMORE CITY HEALTH DEPARTMENT

65 0937

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

EVERETT

R.

APPELBY

2. DATE AND HOUR PRONOUNCED DEAD

January 22, 1965

9:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

518 W. 33rd Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

MAY 27, 1901

9. AGE (In years last birthday)

63

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

POOLE CORP.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WALTER W.

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-10-7260

17. INFORMANT

FLORANCE M. BERRY

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/65

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

1/27/65

23C. NAME OF CEMETERY or CREMATORY

ST. MARY'S

23D. LOCATION

(City, town, or county)

(State)

HAMPDEN

24A. DATE REC'D BY HEALTH DEPT.

JAN 27 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Paul E. Choweth 3617 Chestnut Ave.

ADDRESS

WALLER FORGE

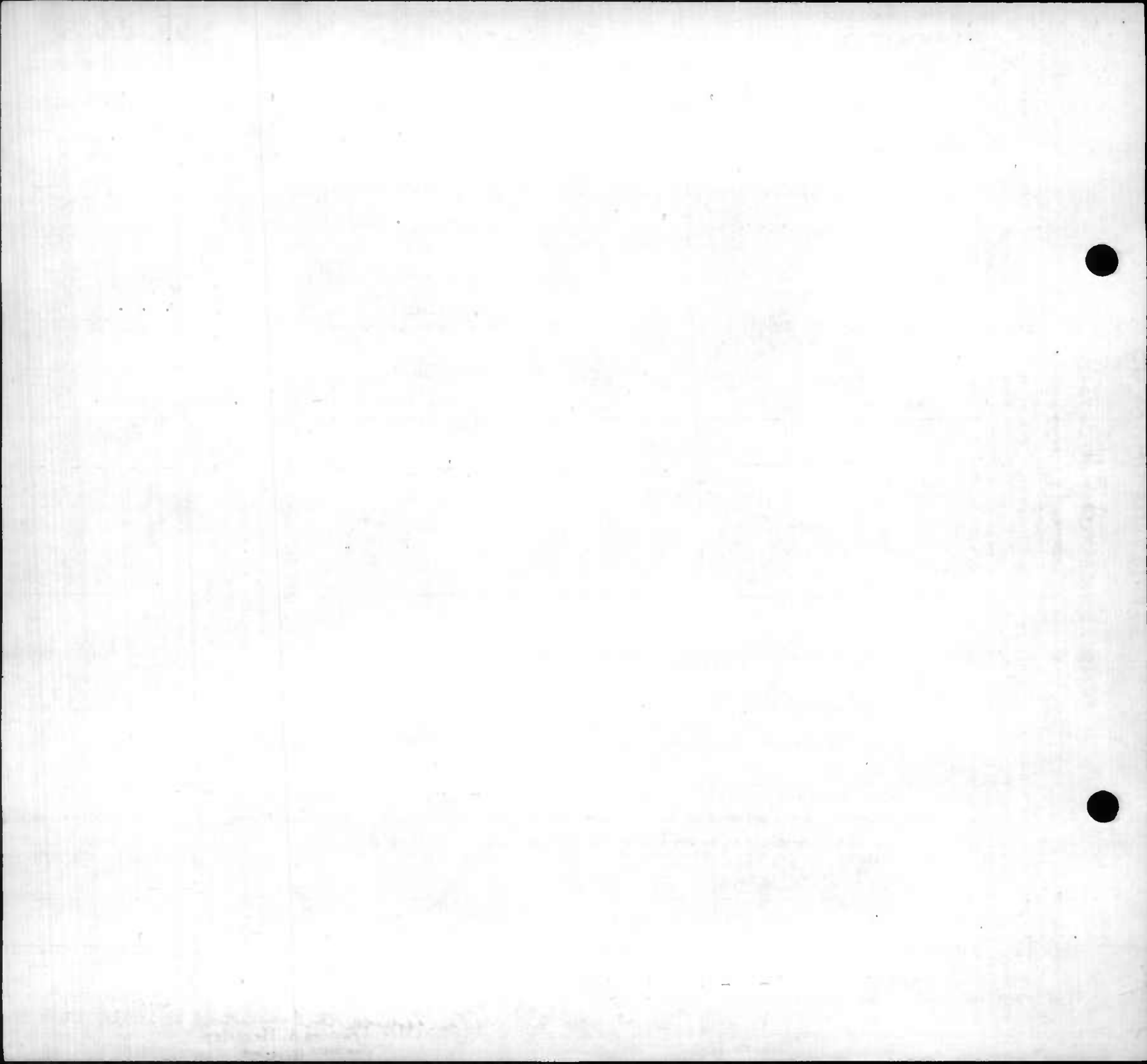
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Chen & Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

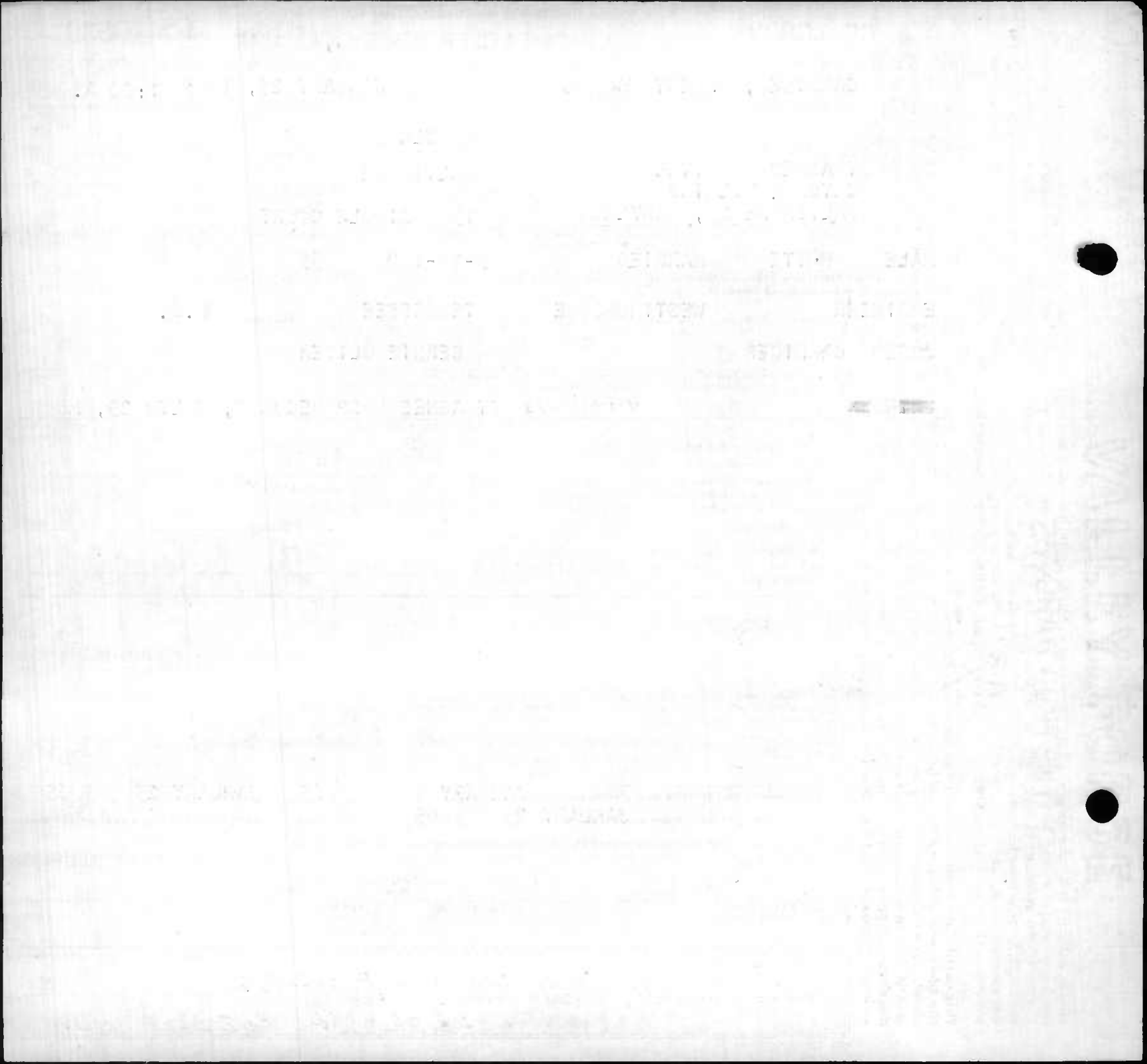
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 0938		CERTIFICATE OF DEATH		Registered No. 65 0938	
1. NAME OF DECEASED (Type or Print) Valentine, Thomas				2. DATE AND HOUR OF DEATH January 22, 1965 10:30p M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore 17, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 586 W. Preston Street					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Valentine				14. MOTHER'S MAIDEN NAME Maggie Simms					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Preston - 586 W. Preston St.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Coronary Heart Disease DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1-22-65-1-22-65	
(B) Aortic Aneurysm DUE TO				(C)					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-22-1965 to 1-22-1965, that (I) (we) lost saw the deceased alive on 1-22-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ahmed				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-23-65		
23C. PHYSICIAN'S NAME (Type) Mohammed Ahmed				23D. ADDRESS M.D. 1514 Division Street-Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Mrs. Frances A. Hemley			25D. ADDRESS 578 Biddle St		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

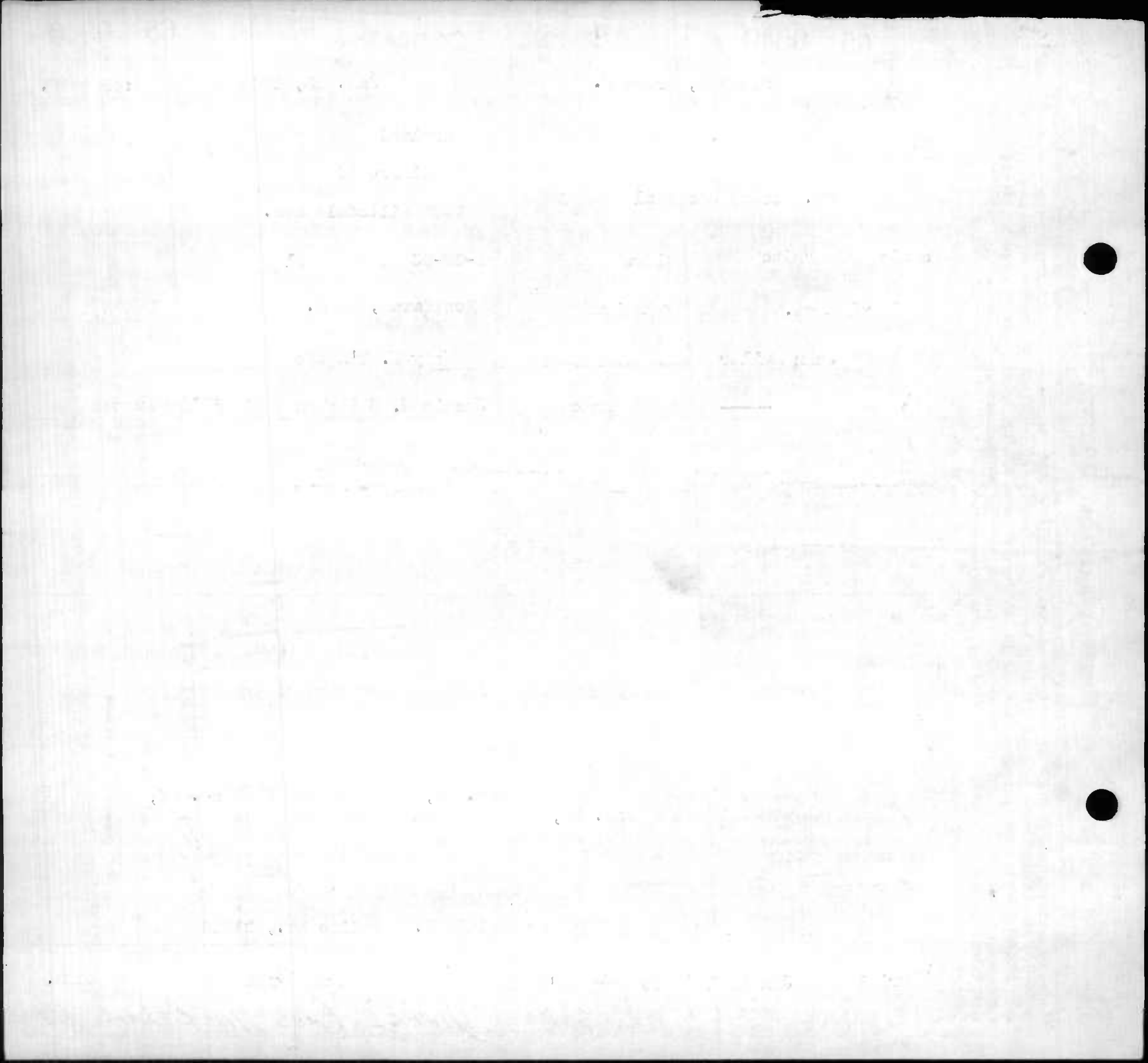
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0939	
BIRTH NO. 65 0939							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) CARRIGER, HUBERT Harold				2. DATE AND HOUR OF DEATH JANUARY 25, 1965 11:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON & WILKINS BALTIMORE 29, MARYLAND				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1307 BIDDLE COURT			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-26-1909	9. AGE (In years last birthday) 55	11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE			
13. FATHER'S NAME JOSEPH CARRIGER				14. MOTHER'S MAIDEN NAME BERNIE OLIVER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 409-05-3433		17. INFORMANT ADDRESS ST AGNES HOSP RECORDS, BALTO 29, MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Generalized Peritonitis; bilateral pneumonia.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Severe pancreatitis.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 6 19 65 to JANUARY 25 19 65 , that (I) (we) last saw the deceased alive on JANUARY 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. N. Zglesia				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/65		24C. NAME OF CEMETERY or CREMATORY Happy Valley Mem. Cem		24D. LOCATION (City, town, or county) (State) ELIZABETH TON TENN.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR E. B. MacNeill		ADDRESS BALTO 21228 MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 0940</u>	
CERTIFICATE OF DEATH							
BIRTH NO. <u>65 0940</u>		M.E. CASE NO. <u>65 0940</u>					
1. NAME OF DECEASED (Type or Print) <u>Callahan, Irene M.</u>				2. DATE AND HOUR OF DEATH <u>Jan. 23, 1965</u> <u>4:45</u> <u>P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Bolton</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #6</u> D. STREET ADDRESS (If rural, give location) <u>7002 Willodale Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-29-83</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legal Sect.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New Haven, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Muller</u>				14. MOTHER'S MAIDEN NAME <u>Mary N. O'Keefe</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Justin M. Callahan 7002 Willow Avenue</u>			
18. <u>332X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis, left</u> DUE TO (A) ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 31, 1964</u> to <u>Jan. 23, 1965</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rostom D. Rivera</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-23-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rostom D. Rivera</u>				23D. ADDRESS M.D. <u>1400 N. Caroline St., 21213</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan 27 1965</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Bernard's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>New Haven Conn.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Vippee Bros. 7110 BELAIR RD</u>			



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65 0941 BALTIMORE CITY HEALTH DEPARTMENT 65 0941

BIRTH NO. _____ M.E. CASE NO. 59394

1. NAME OF DECEASED (Type or Print) OLIVIA WISE 2. DATE AND HOUR PRONOUNCED DEAD January 24, 1965 11:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY _____
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1602
D. STREET ADDRESS (If rural, give location) 609 N. Calhoun Street

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 609 N. Calhoun Street

5. SEX Female 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH March 10-1910 9. AGE (In years last birthday) 54 10. UNDER 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Hulltown Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Raymond Wise Same ADDRESS

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Heart Disease. (A) DUE TO _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO _____
(C) _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? _____ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR? _____

22. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER []
EXAMINER'S NAME (Type) Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [] DATE SIGNED 1/24/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 1/28-1965 23C. NAME OF CEMETERY or CREMATORY Balto Nat Cal 23D. LOCATION (City, town, or county) (State) Baltimore Md

24A. DATE REC'D BY HEALTH DEPT. JAN 27 1965 24B. NAME OF REGISTRAR Robert E. Farley, M.D. 24C. FUNERAL DIRECTOR Choyl Wilson 1000 Brantley ADDRESS

WALTER F. FORD

James H. Ford

James H. Ford
Walter F. Ford

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65 0942 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0942

M.E. CASE NO. 59397

1. NAME OF DECEASED (Type or Print) CLAY PINKETT		2. DATE AND HOUR PRONOUNCED DEAD 1-24-65 7:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL - DOA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 15-12 D. STREET ADDRESS (If rural, give location) 3741 Reisterstown Road - 21215	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Sept 7 78 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Hughes Pinkett		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-3275	
17. INFORMANT Ernestine Johnson		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/29-1965	23C. NAME OF CEMETERY or CREMATORY Arbutus Court
23D. LOCATION Balto Md		23E. FUNERAL DIRECTOR Choy Wilbur 1000 Brantley Dr	
24A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		24B. NAME OF REGISTRAR Robert E. Fisher M.D.	

VS 151-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0943		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0943	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) NETTLES, ROBERT (NMI)			2. DATE AND HOUR OF DEATH 1/24/65 2:50 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1306 N. CAREY ST.		
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/1/95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER (RETIRED)		10B. KIND OF BUSINESS OR INDUSTRY WAVERLY PRESS		11. BIRTHPLACE (State or foreign country) TRENTON, TENN.	
13. FATHER'S NAME DADA NETTLES			14. MOTHER'S MAIDEN NAME EMMA WEBB		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10-29-17 TO 6-3-19		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS V.A. HOSPITAL, BALTIMORE, MD. 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 2 weeks ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIFFUSE PULMONARY EMPHYSEMA OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1. PNEUMOTHORAX, LEFT RIGHT WITH EMPHYSEMA, RIGHT 2. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 2 months 2 weeks					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 4 19 64 to JANUARY 24 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JANUARY 24 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> We) (did) XXXX view the body after death.					
23A. SIGNATURE <i>Anastasio Hoyumpa, Jr.</i> M.D.				23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type) ANASTASIO HOYUMPA, M. D.				23D. ADDRESS V.A. HOSPITAL 3900 LOCH RAVEN BLVD., BALTIMORE, MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/1965		24C. NAME OF CEMETERY or CREMATORY Balto Natl Cem	
24D. LOCATION Balto Md		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Clayton G. Wilson 1000 Brantley Ave	

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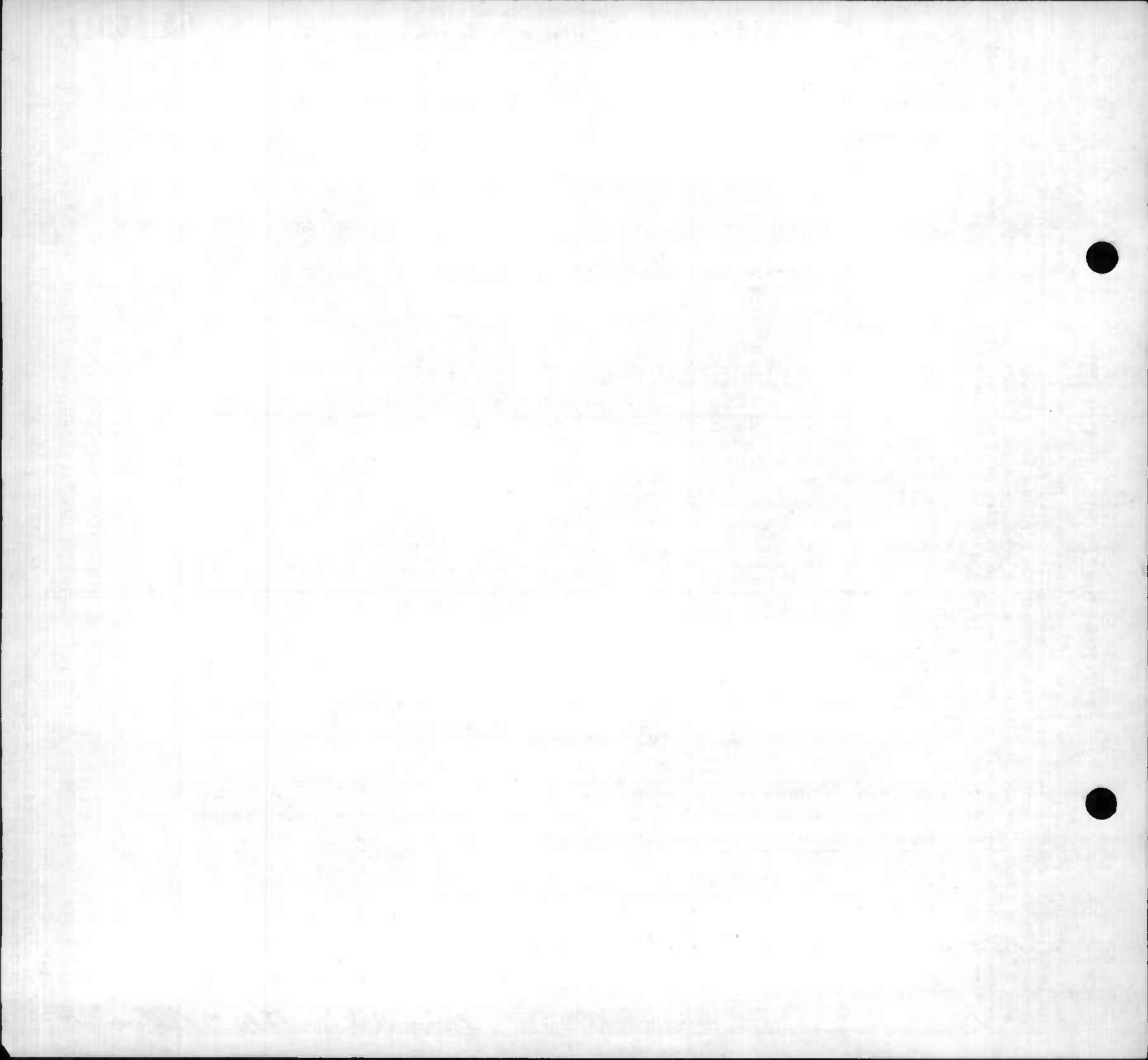
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

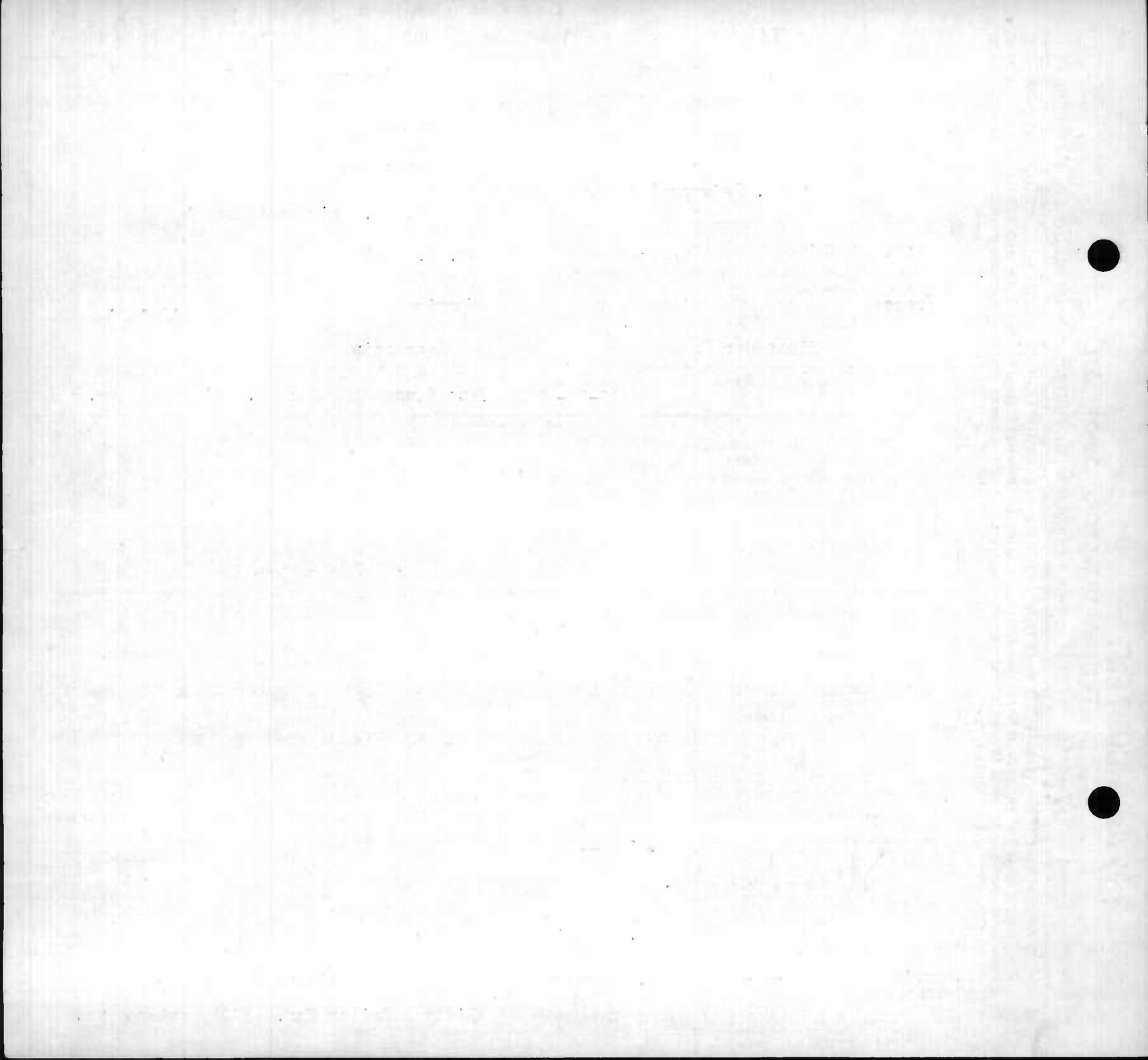
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0944					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 0944				
1. NAME OF DECEASED (Type or Print) <u>Blackwell, William A.</u>					2. DATE AND HOUR OF DEATH <u>1-25-65</u> <u>12 Noon</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>Baltimore 1, Md.</u>					A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 17</u>					D. STREET ADDRESS (If rural, give location) <u>2206 Etting Street</u>				
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>1-21-06</u>	9. AGE (in years last birthday) <u>59</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Theodore Blackwell</u>					14. MOTHER'S MAIDEN NAME <u>Sadie Day</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-07-7191</u>		17. INFORMANT <u>Hosp. Record</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma Colon.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Old Myocardial Infarct</u>									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>7-6-63</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Segmental Resection Colon</u>			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> <u>1965</u> to <u>1-25</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Ronald D. Snyder M.D.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1-25-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALD D. SNYDER, MD</u>					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-29-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>George H. Kelen 1348 N. Calhoun St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

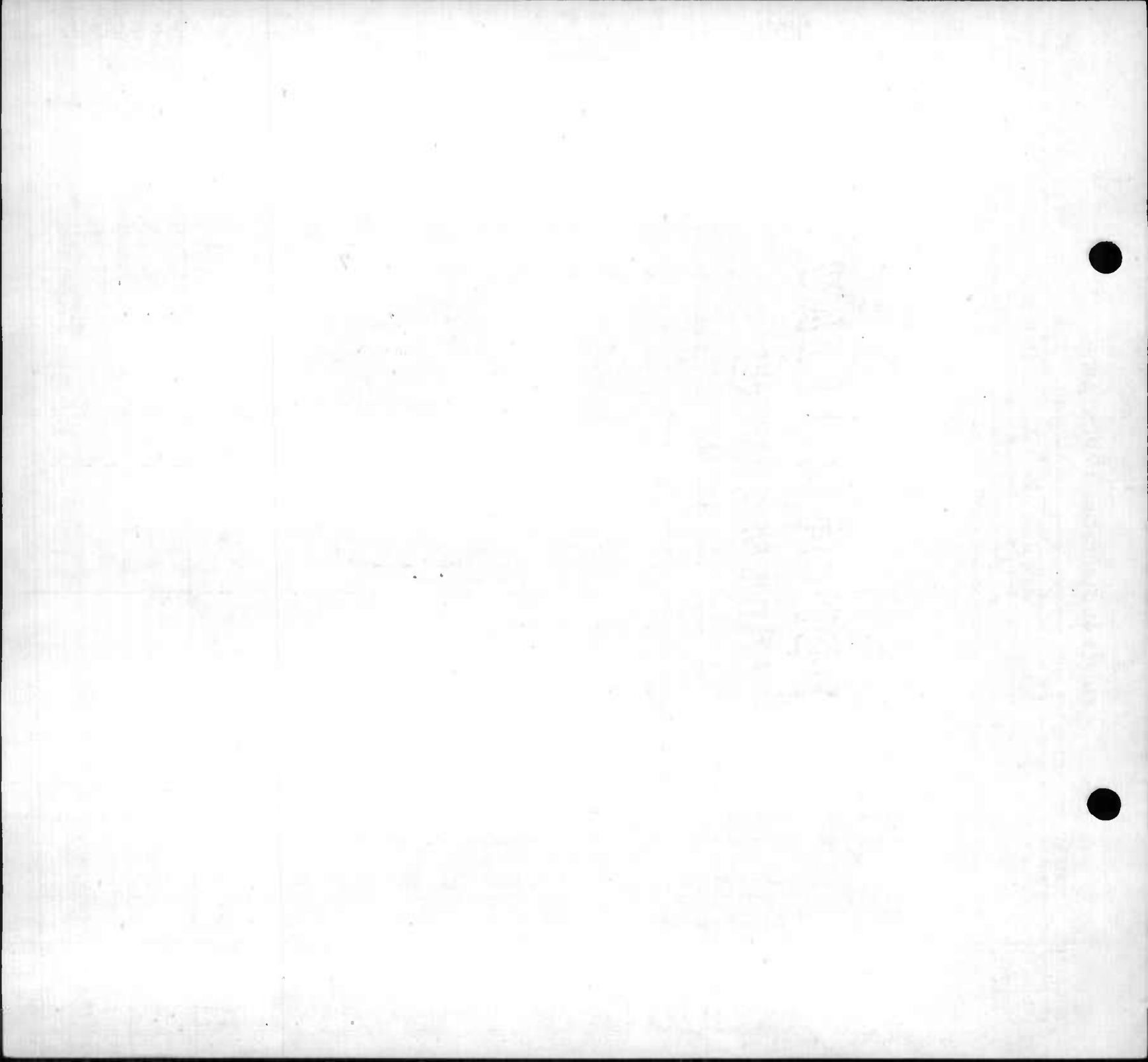
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0945	
BIRTH NO. 65 0945		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANNA DOMNENKO			2. DATE AND HOUR OF DEATH January 25, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland B. COUNTY 6-03		
2326 E. Fairmount Avenue			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2326 E. Fairmount Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 1, 1902	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months Days 10. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10B. KIND OF BUSINESS OR INDUSTRY Tailor Shop	11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Alexander Czhech			14. MOTHER'S MAIDEN NAME Anastasia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-34-1942	17. INFORMANT ADDRESS Iwan Domnenko 2326 E. Fairmount Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Respiratory Arrest		
			(B) Carcinomatosis		
			(C) Cancer of Breast.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 01-27-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Ca		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 19 1965 to Jan 25 1965, that (I) (we) last saw the deceased alive on Jan 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE [Signature]		23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type) MONTAGUE		23D. ADDRESS 610 MED. ARTS.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-1965		24C. NAME of CEMETERY or CREMATORY St. Andrews	
24D. LOCATION Baltimore County, Maryland		24E. CITY, town, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

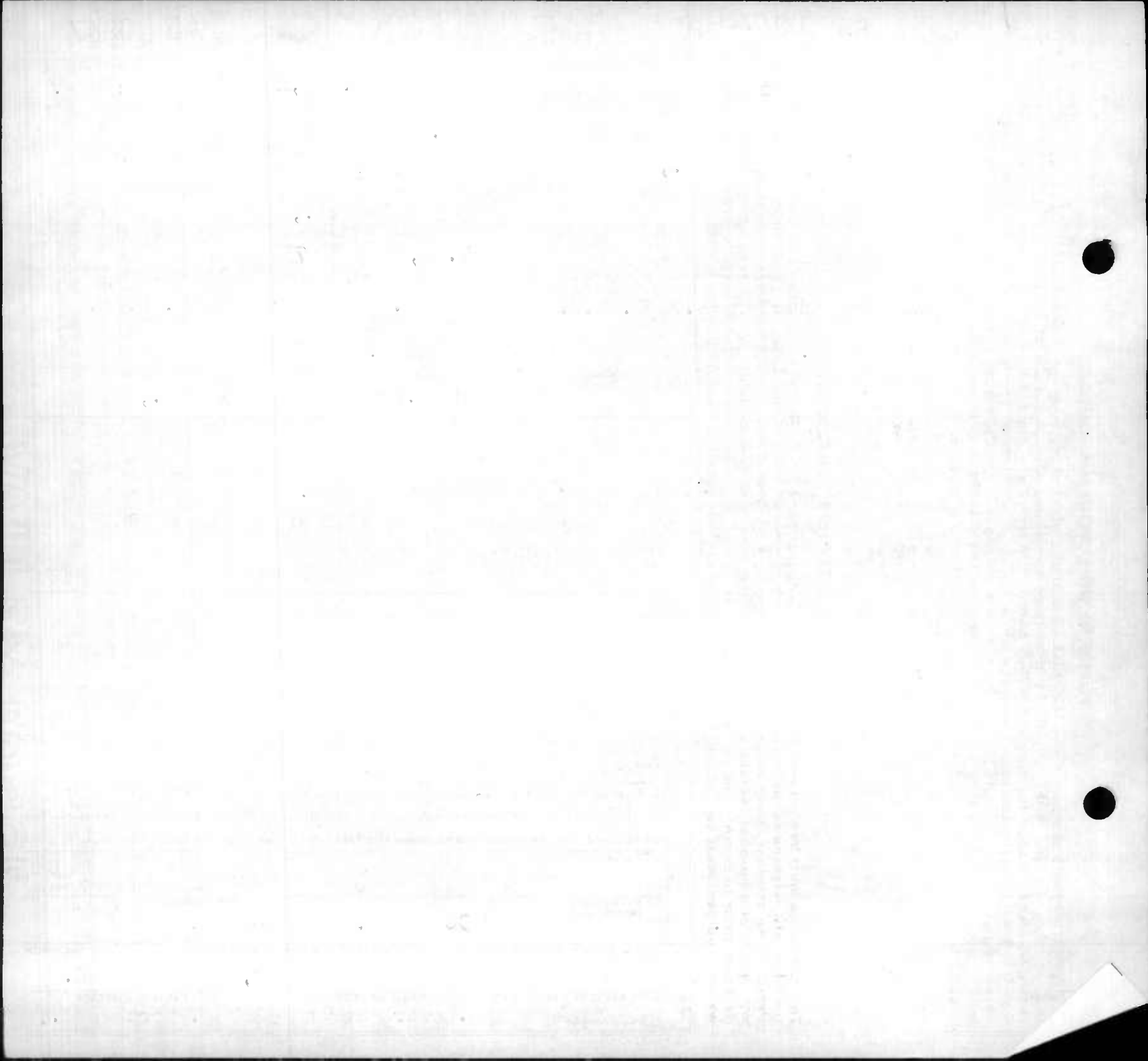
BIRTH NO. 65 0946				CITY HEALTH DEPARTMENT		REGISTERED NO. 65 0946	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mary Matthews				2. DATE AND HOUR OF DEATH January 22, 1965 11:10a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore 17, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1402 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1508 Brunt Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH August 21, 1917 47		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Floyd Matthews				14. MOTHER'S MAIDEN NAME Victoria Porter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lucretia Twine		ADDRESS 546 Mosher St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 381-14 002.1 CAUSE OF DEATH (A) Hepatic Coma DUE TO (B) Cirrhosis of Liver DUE TO (C) Chronic Alcoholism II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Tuberculosis				INTERVAL BETWEEN ONSET AND DEATH 1-21-65-1-22-65			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-21 19 65 to 1-22- 19 65 , that (I) (we) last saw the deceased alive on 1-22-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hollis Seunarine, M.D.						23B. DATE SIGNED January 22, 1965	
23C. PHYSICIAN'S NAME (Type) Hollis Seunarine				23D. ADDRESS 1514 Division Street - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore County Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Herbert B. Nutter		ADDRESS 3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0947				
BIRTH NO. 65 0947					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Howard LeRoy Veasel					2. DATE AND HOUR OF DEATH Jan. 25, 1965 5:00 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 313 Yale Ave.,					A. STATE Md.				
					B. COUNTY 20-08				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 313 Yale Ave.,				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Feb. 20, 1891	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman Conductor			10B. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George W. Veasel					14. MOTHER'S MAIDEN NAME Emma M. Stahl				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Emma B. Veasel 313 Yale Ave.,				
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Arteriosclerotic Cardio-vascular disease. DUE TO (B) Chronic myocardial disease DUE TO (C) Cardiac arrest			INTERVAL BETWEEN ONSET AND DEATH years 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 4 1963 to January 23 1965 , that (I) (we) last saw the deceased alive on January 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Irwin H. Moss, M.D.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 25 January 65	
23C. PHYSICIAN'S NAME (Type) Irwin H. Moss					23D. ADDRESS M.D. 5836 Balto. National Pike				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1965		24C. NAME of CEMETERY or CREMATORY Loudon Park			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR G. Howard Strong			ADDRESS 3207 W. North Ave.,	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0948	
BIRTH NO. 65 0948				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Camilla T. Brown				January 25, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Nursing Home				A. STATE Maryland	
				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 4818 Lindsay Road	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan. 23, 1881	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oswald			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Evelyn Brown 4814 Lindsay Road
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Arterio-sclerotic Cardio-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH ?
			(B) DUE TO 7		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/2 19 59 to 1/26 19 65 , that (I) (we) last saw the deceased alive on 1/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum				23B. DATE SIGNED 1/26/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D.				23D. ADDRESS 1115 N. CALVERT ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Ellsworth Armacost	
ADDRESS 4600 Liberty Heights					

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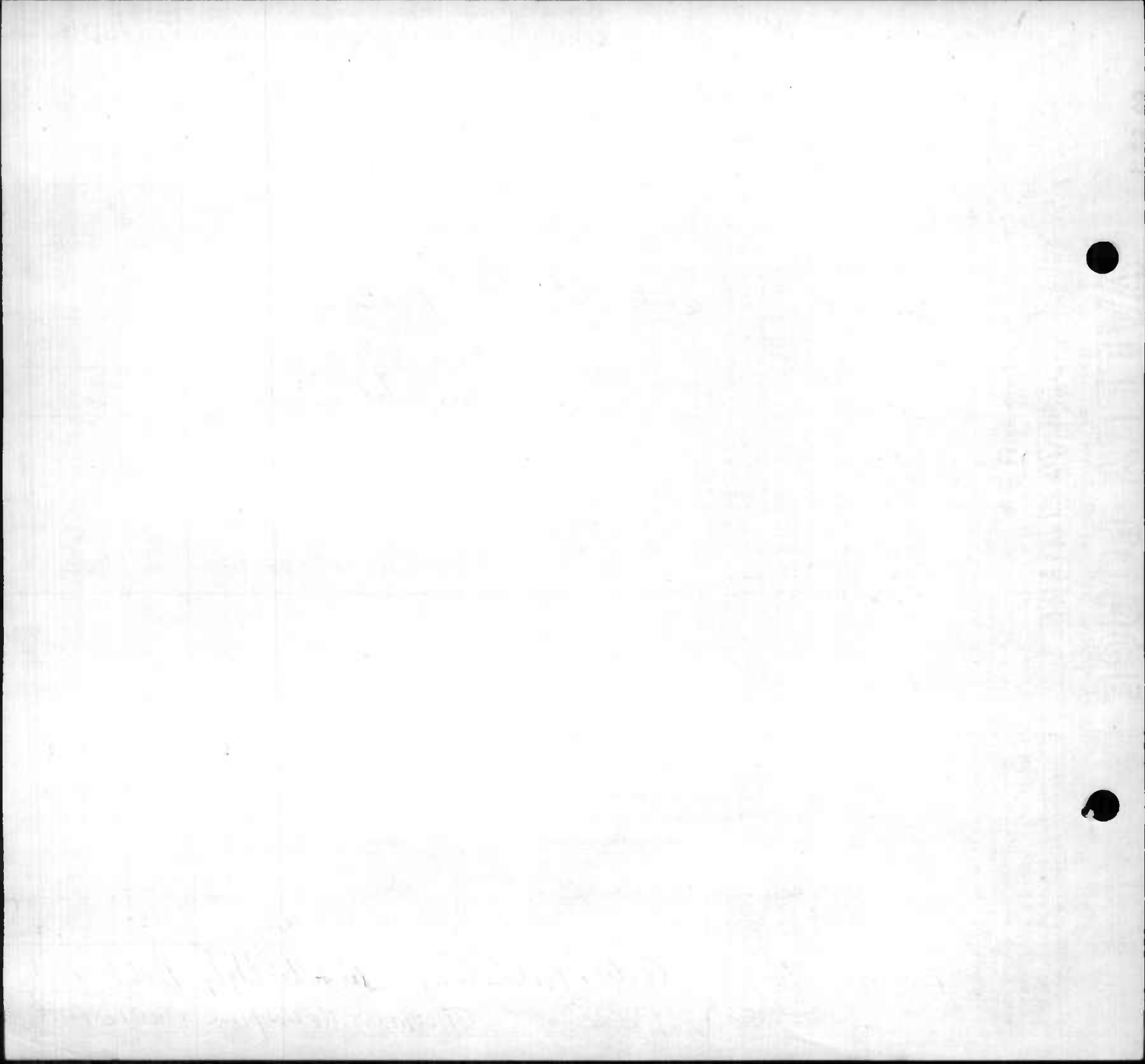
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FUNERAL DIRECTOR: IMPORTANT

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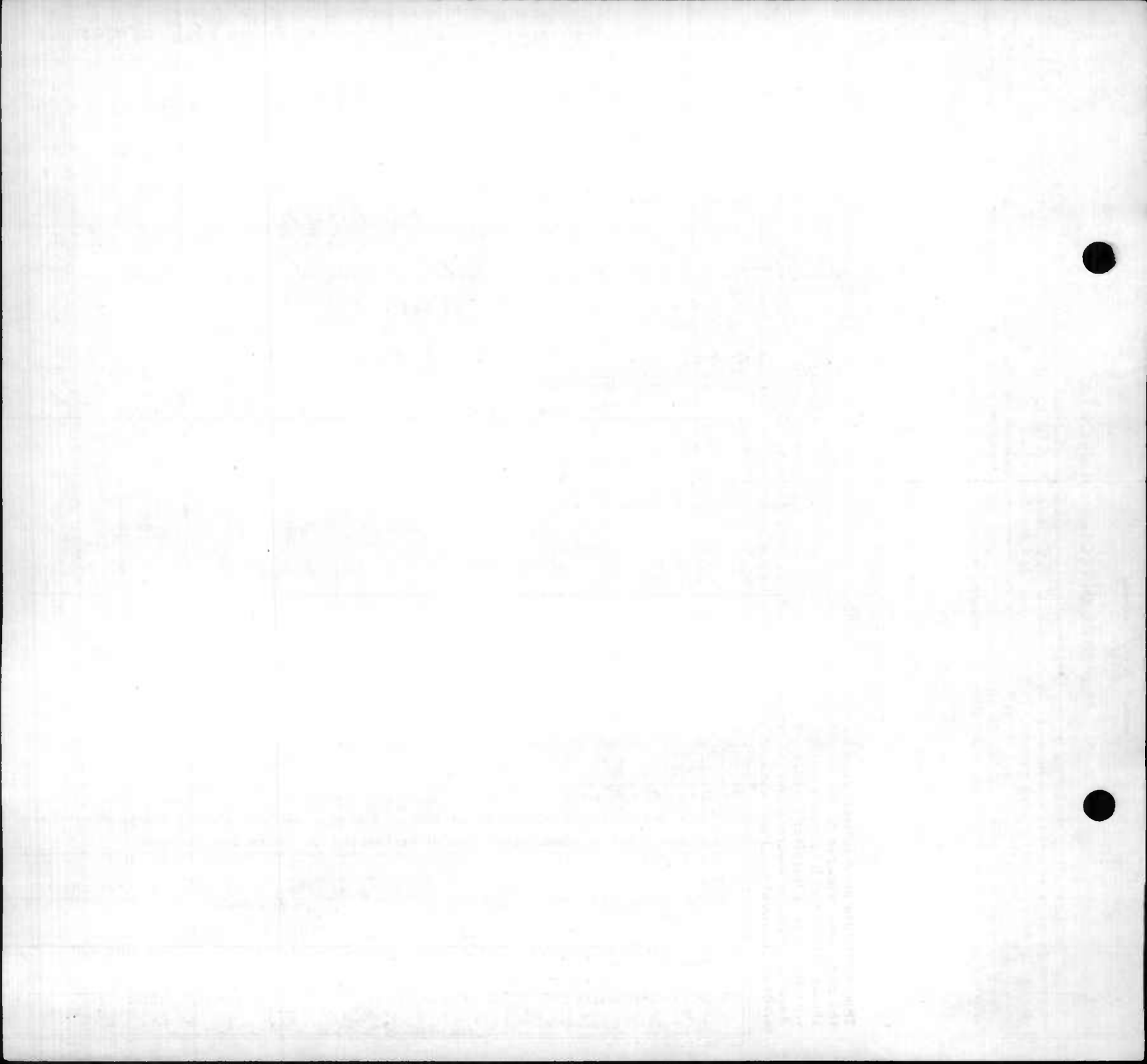
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0949	
BIRTH NO. 65 0949		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GREEN, AMOS			
2. DATE AND HOUR OF DEATH 1-25-65		12:50 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 18-03			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 19 S. ARLINGTON AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2/15/15	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward Green			
14. MOTHER'S MAIDEN NAME Frances Fitzhugh		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No			
16. SOCIAL SECURITY NO. 217-10-8220		17. INFORMANT Hospital Records			
18. 420.11		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Pulmonary Embolism DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CARDIAC MURAL Thrombosis DUE TO			
		(C) Myocardial infarction x3 2 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-29 19 65 to 1-25 19 65 , that (I) (we) last saw the deceased alive on 1-25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Bigger, Jr MD M.D.				23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type) JOHN F. BIGGER, JR MD				23D. ADDRESS Johns Hopkins Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/28/65		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem	
24D. LOCATION (City, town, or county) (State) Pitcher Hwy Baeto Md		25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965			
25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc Baeto Md			



FUNERAL DIRECTOR: IMPORTANT

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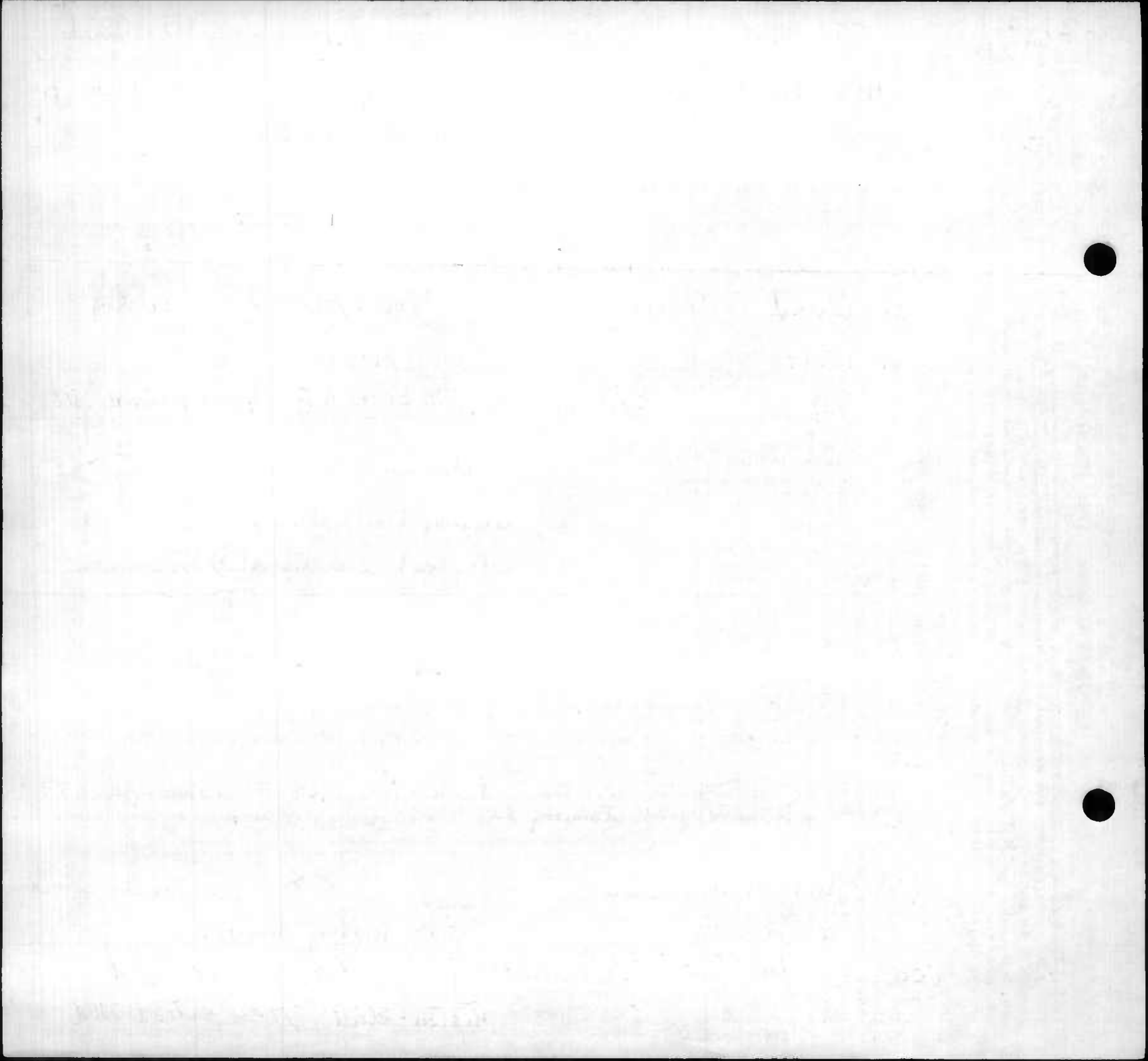
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0950</u>	
BIRTH NO. <u>65 0950</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>EMMA JONES</u>				2. DATE AND HOUR OF DEATH <u>1/23/65</u> <u>13:52 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<u>2324 Eutaw Pl.</u>				<u>md.</u>		<u>13 03</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<u>Balto.</u>			
				D. STREET ADDRESS (If rural, give location)			
				<u>2324 Eutaw Pl.</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>F.</u>	<u>negro</u>	<u>widow</u>	<u>9/3/77</u>	<u>87</u>	<u>housewife</u>	<u>md.</u>	<u>U. S. A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
<u>John W. Coombs</u>			<u>Martha Stone</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		
<u>no</u>			<u>none</u>		<u>Beatrice Brown - 2324 Eutaw Pl.</u>		
18. <u>7-20-1</u> I			CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO <u>Myocardial Infarction</u>				<u>1 hour</u>
ANTECEDENT CAUSES			(B) DUE TO <u>Generalized Arteriosclerosis</u>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <u>Chronic Pyelonephritis</u>				<u>2 mos.</u>
II			Cerebral Thrombosis				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19 63</u> to <u>1-23 19 65</u> , that (I) (we) last saw the deceased alive on <u>1-21 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles R. Venter</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1-23-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles R. Venter</u>				23D. ADDRESS <u>2320 Eutaw Place</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-27-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Pleasant Rest Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>William L. Chetman, Jr.</u> ADDRESS <u>1701 McCulloch St. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

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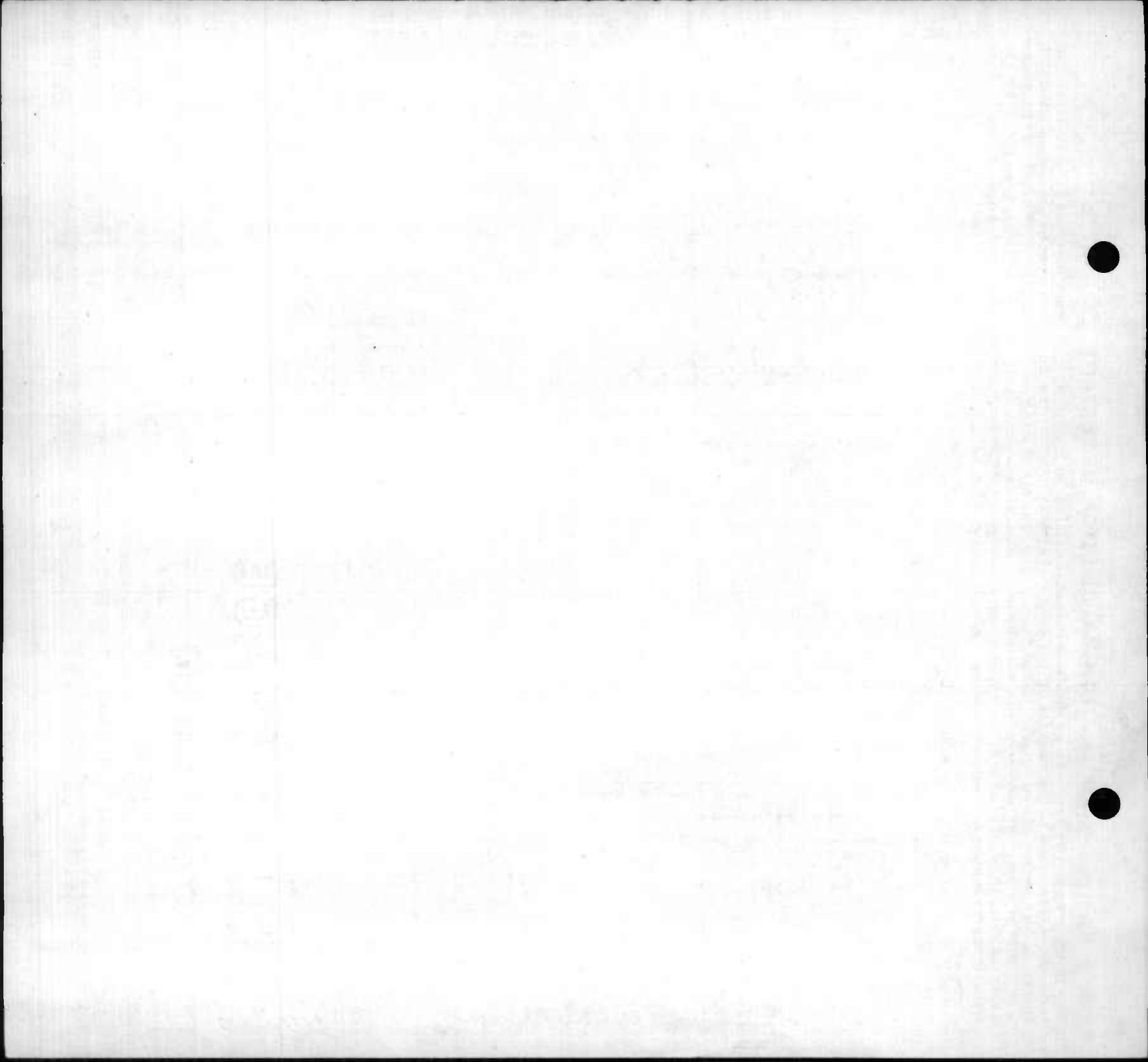
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0951</u>	
BIRTH NO. <u>65 0951</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Utz, Preston W.</u>		2. DATE AND HOUR OF DEATH <u>1/20/65</u> <u>1:00 p.m.</u>	
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CARROLL</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>HAMPSTEAD</u>		D. STREET ADDRESS (If rural, give location) <u>323 NORTH MAIN STREET</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-8-94</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM UTZ</u>				14. MOTHER'S MAIDEN NAME <u>LAURA RIVEMAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-05-0732</u>		17. INFORMANT <u>Mrs Grace Utz - Hampstead Md</u>	
18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Urinary tract infection</u>				<u>5 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Left Cerebrovascular accident</u>				<u>1 month</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>January 6, 1965</u> to <u>January 20, 1965</u> , that <u>(I) (we)</u> lost saw the deceased alive on <u>January 20, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert O Bleakman</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 29, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT O BLEAKMAN</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan 29/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Jasky, M.D.</u>		25C. FUNERAL DIRECTOR <u>Tipton + Blair</u>		ADDRESS <u>Hampstead Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

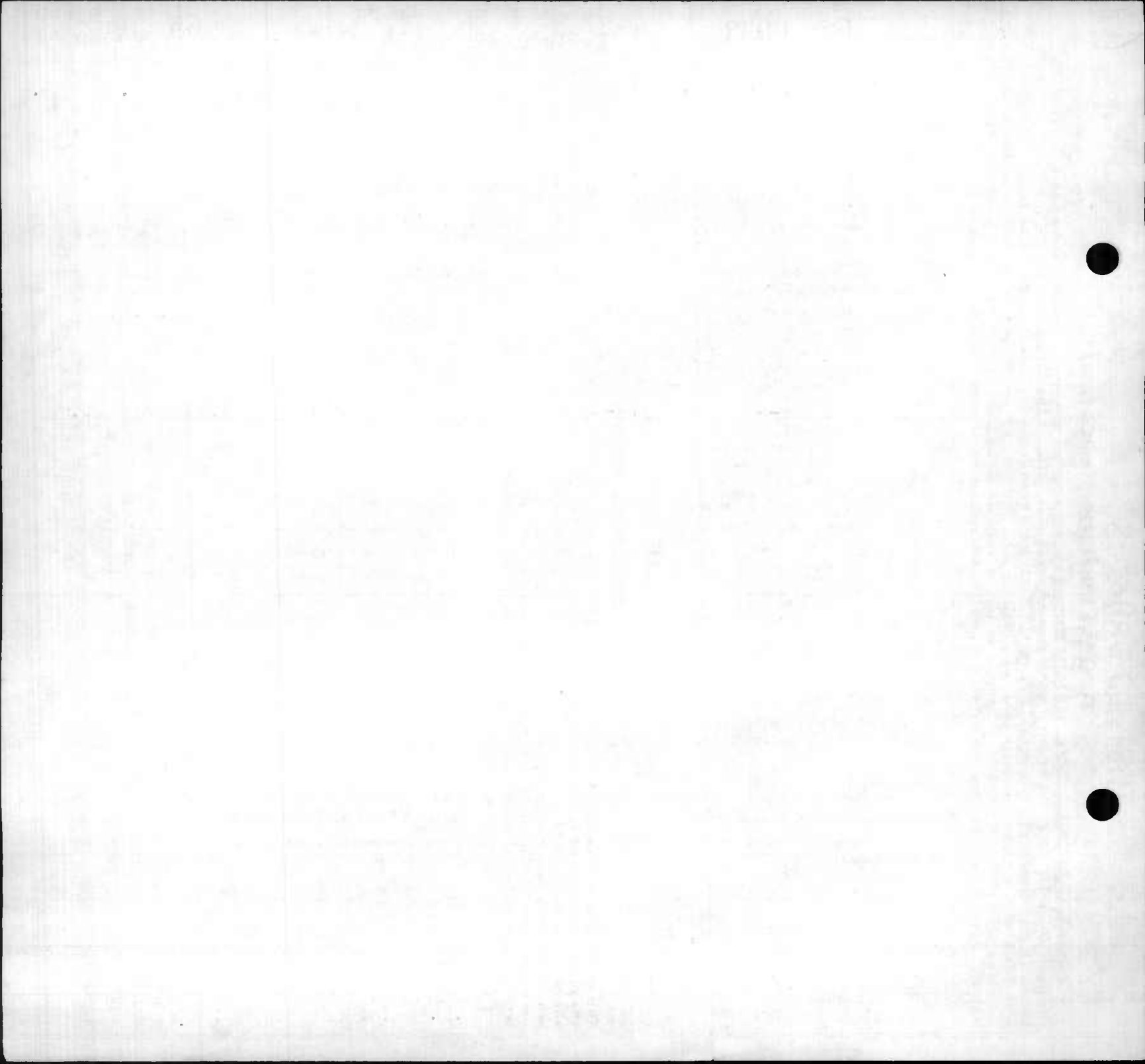
BALTIMORE CITY HEALTH DEPARTMENT				65 0952	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. 65 0952		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) WEISMANTEL, HUGO LOUIS		2. DATE AND HOUR OF DEATH 1. 25. 65 5:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital		A. STATE MISSOURI			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ST. LOUIS			
		D. STREET ADDRESS (If rural, give location) 6560 LINDEN WOOD PLACE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/9/90	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME LOUIS A. WEISMANTEL		14. MOTHER'S MAIDEN NAME AMANDA SCHNITKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Hawkins. 2109 Slawson Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 584X1 CAUSE OF DEATH BILATERAL PNEUMONIA & ATELECTASIS, Pulmonary emboli, bilateral & infarct CHOLECYSTECTOMY for ACUTE GANBRENOUS CHOLECYSTITIS WITH CHOLELITHIASIS + VENTRAL HERNIA INTERVAL BETWEEN ONSET AND DEATH 29 days		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OPERATIONS: DEC 30, 64 CHOLECYSTECTOMY x REPAIR OF VENTRAL HERNIA JAN 22, 65 BRONCHOSCOPY JAN 25, 65 TRACHEOSTOMY			
19A. DATE OF OPERATION 12/30, 1/22, 1/25		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SEE ABOVE		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White A1 <input type="checkbox"/> Not White A1 Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1. 22 19 65 to 1. 25 19 65, that (I) (we) last saw the deceased alive on 1. 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED 1. 25. 65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS The Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-65		24C. NAME of CEMETERY or CREMATORY Sunset Memorial	
24D. LOCATION (City, town, or county) (State) St. Louis, MO.		25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Frank H. Newell, Jr.		25D. ADDRESS [Address]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

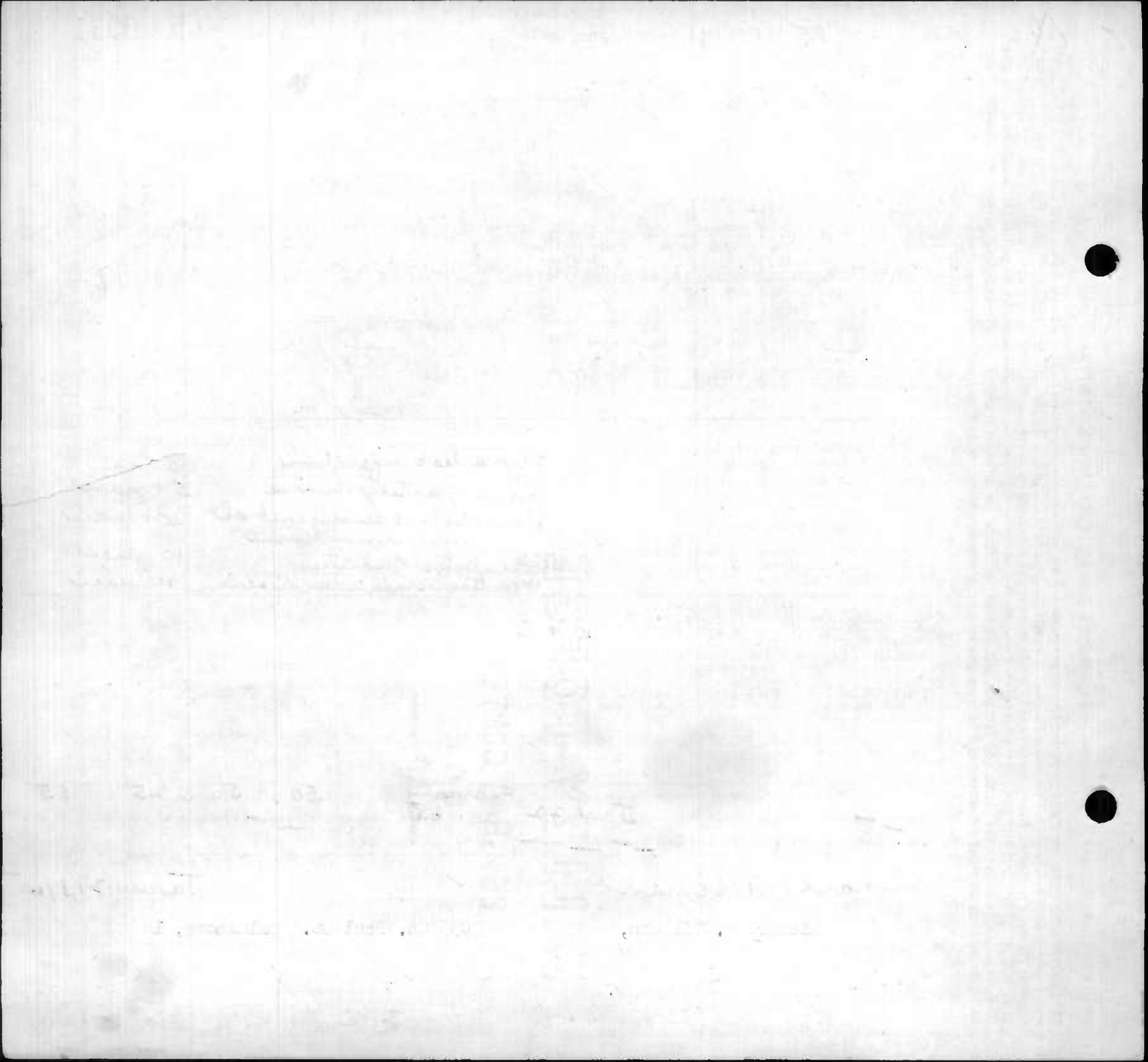
BIRTH NO. 65 0953		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 0953	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARRY B. SMITH		2. DATE AND HOUR OF DEATH January 25, 1965 8.45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION House in the Pines Nursing Home 2525 W. Belvedere Avenue		D. STREET ADDRESS (If rural, give location) 505 S. Glover Street		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/23/1886	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Cemetery	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John M. Smith		14. MOTHER'S MAIDEN NAME Emma Nelson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-05-6300		17. INFORMANT Miss Mary Price, 505 S. Glover St.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarction (B) DUE TO Coronary Artery Disease (C) DUE TO 104		INTERVAL BETWEEN ONSET AND DEATH 104	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 25 1965 to Jan 25 1965 , that (I) (we) last saw the deceased alive on Jan 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/27/65	
23C. PHYSICIAN'S NAME (Type) LESTER N, KOLMAN		M.D. 23D. ADDRESS 3700 PARK HEIGHTS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME OF CEMETERY or CREMATORY Pine Grove	
24D. LOCATION (City, town, or county) (State) Ridgeville, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0954	
BIRTH NO. ③ 65 0954							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Mamie Fava				2. DATE AND HOUR OF DEATH Jan. 25/65 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 840 Wildwood Pkwy				A. STATE Md B. COUNTY 16-08			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 29			
				D. STREET ADDRESS (If rural, give location) 840 Wildwood Pkwy			
5. SEX Female	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Nov. 30/86	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A. - 50 yrs	
13. FATHER'S NAME Salvatore M. Pietra				14. MOTHER'S MAIDEN NAME Concetta			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Vincent Fava, 840 Wildwood Pkwy	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Myocardial infarction (B) Coronary artery disease (C) Rheumatic heart disease, mitral valve involvement Diabetes mellitus Hypertensive Cardiovascular disease		2 hrs 5+ years 20+ years 10 years 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. B + C							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 1950 to Jan 25 1965 , that (I) (we) last saw the deceased alive on Jan 22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Richard N. Tillman				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED January 27, 1965	
23C. PHYSICIAN'S NAME (Type) Richard N. Tillman,				23D. ADDRESS M.D. 3035 St. Paul St. Baltimore, 18			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial Jan. 29/65		New Cathedral		Balto. Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Witzke T. H., 410 Edmondson		ADDRESS the	

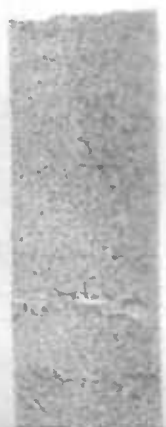


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

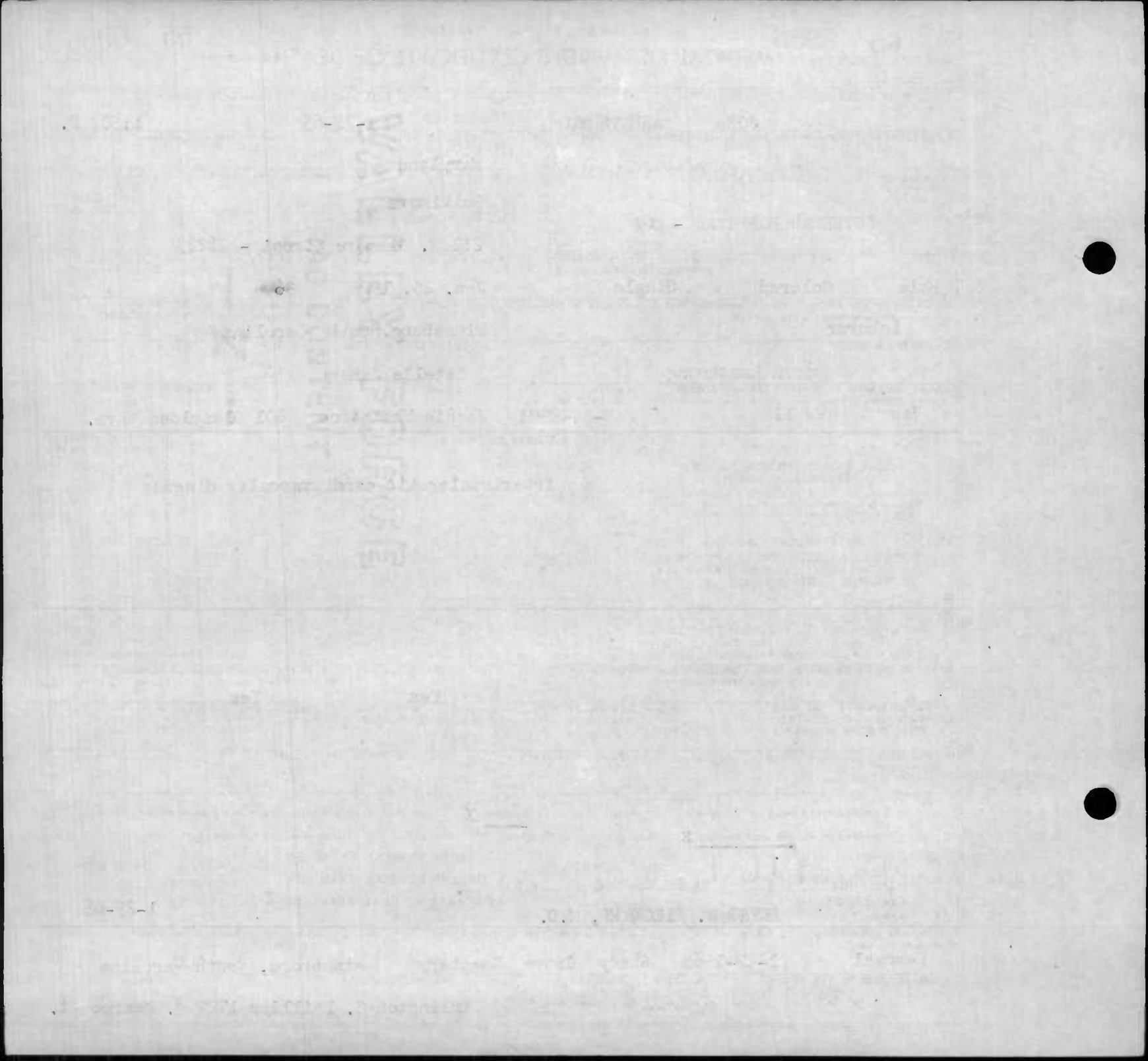
W-325		65 0955		BALTIMORE CITY HEALTH DEPARTMENT		65 0955	
BIRTH NO. <u>6</u> 65 0955				CERTIFICATE OF DEATH X Registered No.			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Watson</u>				1-24-65 10:10 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<u>Bon Secours Hospital</u>				<u>MARYLAND</u>		<u>BALTO</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<u>BALTIMORE 28</u>			
				D. STREET ADDRESS (If rural, give location)			
				<u>102 FOREST DRIVE</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
<u>Female</u>	<u>White</u>	<u>MARRIED</u>	<u>2-5-97</u>	<u>67</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>WIFE H.W.</u>			<u>Own Home</u>		<u>PENNA</u>		<u>AMERICAN</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>AMBROSE WIRTH</u>				<u>EMMA LIGHTY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
<u>No</u>				<u>Wm. Watson</u>		<u>Admission Street 102 Forest Dr.</u>	
18. <u>1750 I</u>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) <u>Generalized Abdominal</u>			
ANTECEDENT CAUSES				(B) <u>Carcinoma, probable</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>ovarian origin</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 12 65</u> to <u>1 24</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Constance Polychronaki</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-24-65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 28/65</u>		<u>New Calver</u>		<u>Balto. 29-Md</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>JAN 27 1965</u>		<u>Robert E. Fisher M.D.</u>		<u>White F.M. 4101 Edison Ave</u>			

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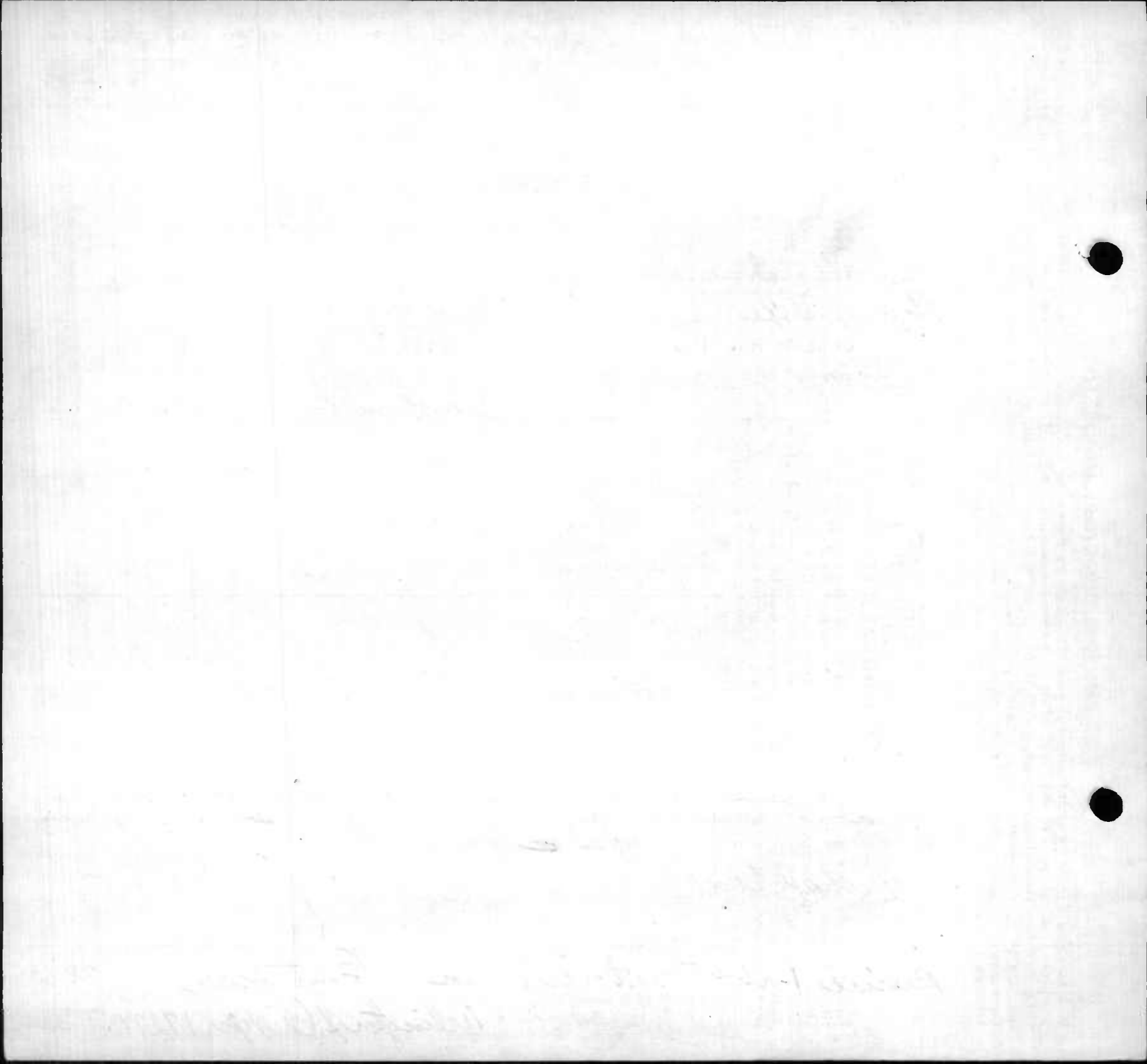
BIRTH NO. 65 0956		BALTIMORE CITY HEALTH DEPARTMENT		65 0956	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print) JOHN ARMSTRONG			2. DATE AND HOUR PRONOUNCED DEAD 1-24-65 1:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL - DOA			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1902 D. STREET ADDRESS (If rural, give location) 212 N. Gilmore Street - 21223		
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Jan. 25, 1928	9. AGE (In years last birthday) 36	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winnsboro, South Carolina	
13. FATHER'S NAME Damon Armstrong			14. MOTHER'S MAIDEN NAME Estelle James		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 249-44-8994		17. INFORMANT ADDRESS Jannie Whetstone 601 Glenolden Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter W. Rieckert M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-25-65					
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 1-27-1965		23C. NAME OF CEMETERY or CREMATORY Shady Grove Cemetery	
24A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.	
24D. LOCATION (City, town, or county) (State) Winnsboro, South Carolina					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

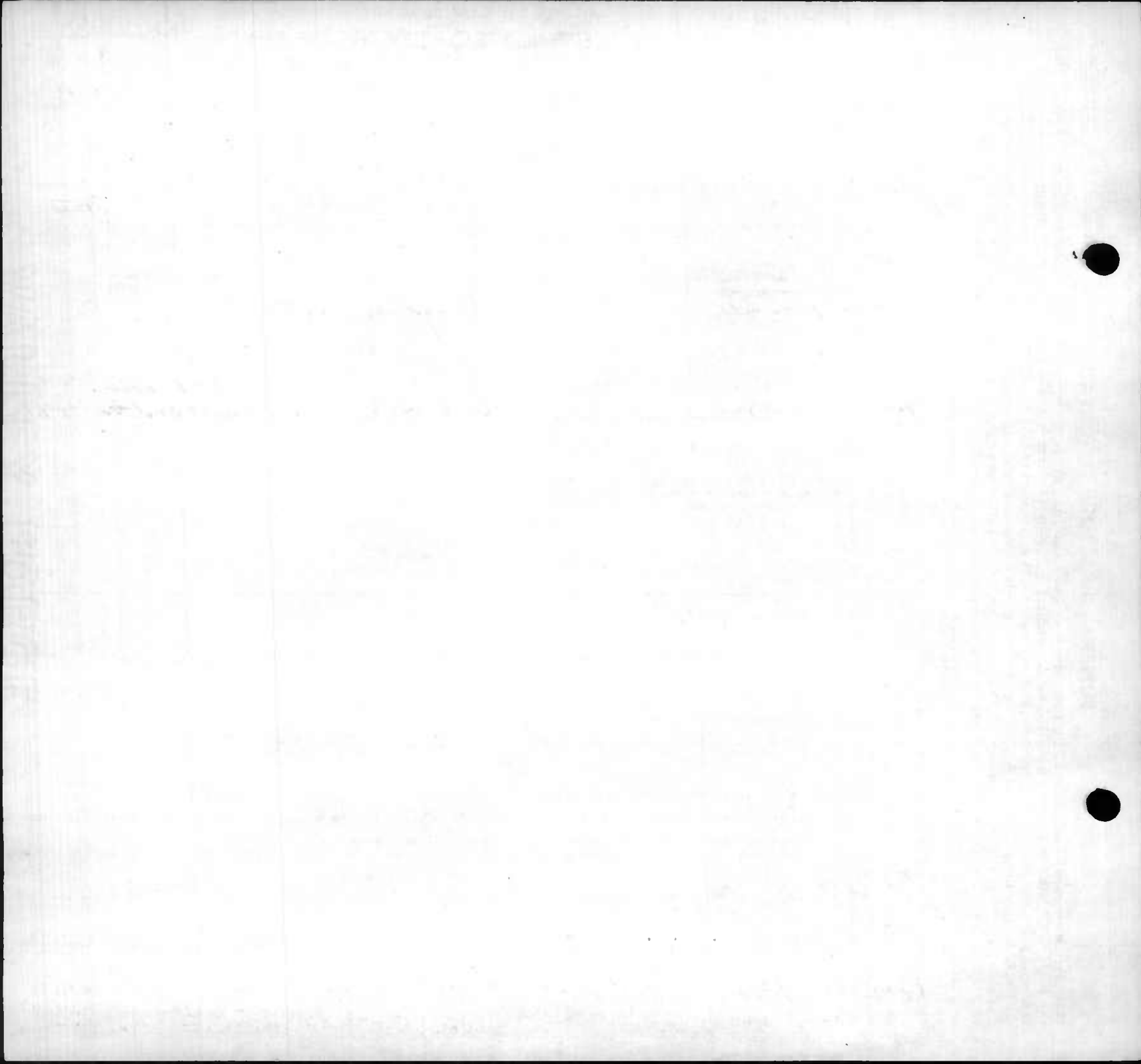
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0957</u>	
BIRTH NO. <u>65 0957</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SUSIE GIVENS</u>		2. DATE AND HOUR OF DEATH <u>1-23-65</u> <u>2.45 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>7-05</u>			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE CITY</u>			
		D. STREET ADDRESS (If rural, give location) <u>1508 EAST MONUMENT STREET</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED <u>WIDOW</u>	8. DATE OF BIRTH <u>4-19-14</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>JOSEPH HAWKINS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clayborn Bartley</u> ADDRESS <u>906 Hardman</u>	
18. <u>330X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Sub Arachnoid Hemorrhage</u> DUE TO (B) <u>Hypertension</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>1/22/65 3PM</u> 19 <u>65</u> to <u>2:45 AM</u> <u>1/23</u> 19 <u>65</u> , that (1) <u>last</u> saw the deceased alive on <u>1/23/</u> 19 <u>65</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>did</u> view the body after death.					
23A. SIGNATURE <u>Michael Leach</u>				23B. DATE SIGNED <u>1/23/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL LEACH</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-26-65</u>		24C. NAME of CEMETERY or CREMATORY <u>mt. Auburn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 N. Mount St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

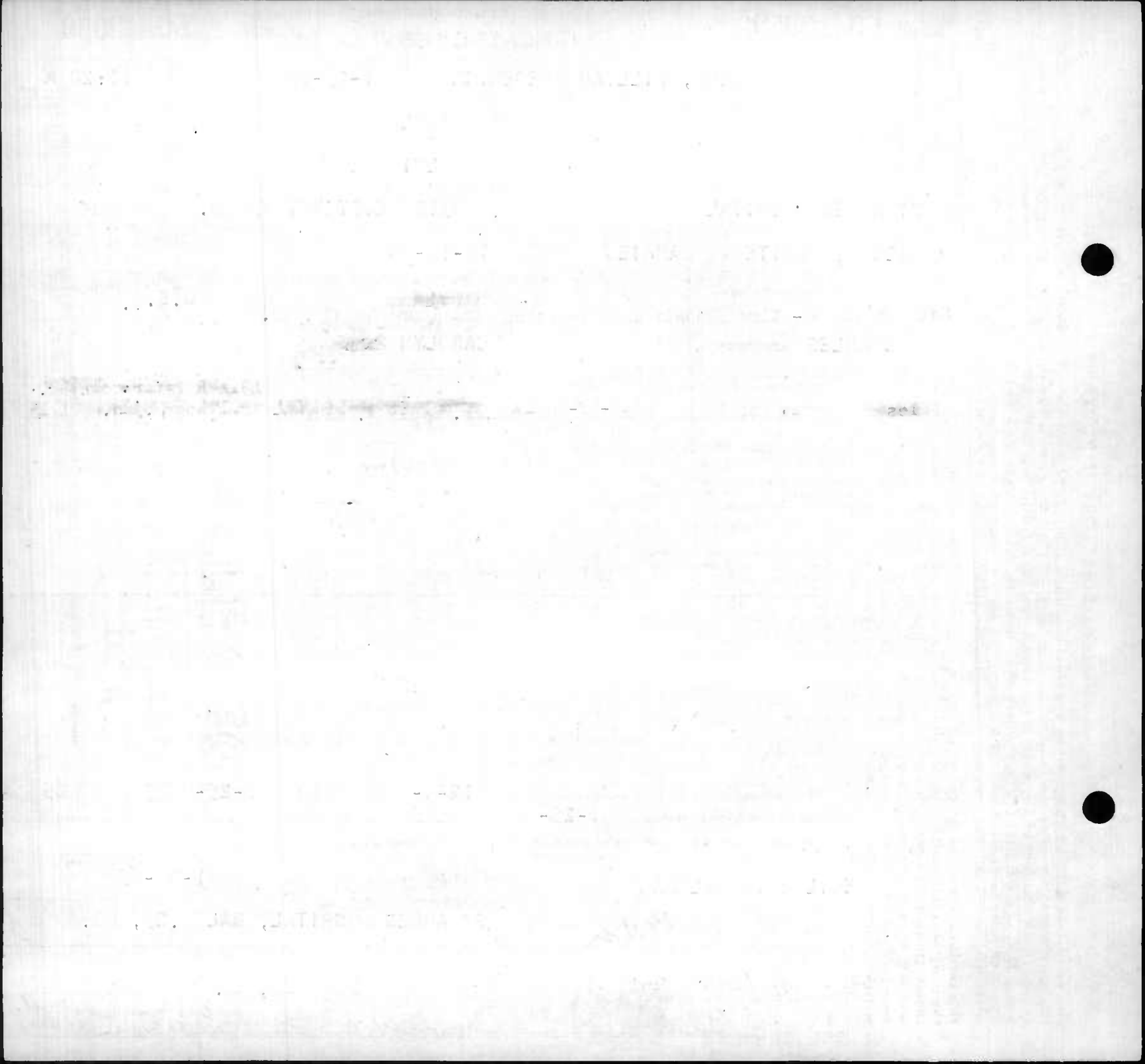
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 0958	
BIRTH NO. 65 0958							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) ANNA K. Young				2. DATE AND HOUR OF DEATH 1/26/65 4:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				A. STATE Maryland B. COUNTY 2603			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 61			
D. STREET ADDRESS (If rural, give location) 4108-Erdman Ave.							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 1-7-73	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Franklin Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Alexander				14. MOTHER'S MAIDEN NAME Susan Rook			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No none		16. SOCIAL SECURITY NO.		17. INFORMANT Sellers Funeral Home Chambersburg, Pa.			
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO MI ASCVD		INTERVAL BETWEEN ONSET AND DEATH 7-2 weeks	
				(B) DUE TO			
				(C) DUE TO			
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 1/16/65 19 65 to 1/26 19 65 that (I) (we) lost saw the deceased alive on 1/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J.R. Caldwell, M.D.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/26/65	
23C. PHYSICIAN'S NAME (Type) J.R. Caldwell, DR. J.R. CALDWELL				23D. ADDRESS Johns Hopkins Hospital - Dept. of Medicine			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/26/65		24C. NAME OF CEMETERY or CREMATORY Lincoln Cemetery		24D. LOCATION (City, town, or county) (State) Chambersburg, Pa.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. J. Dickman & Sons North & Pa. Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

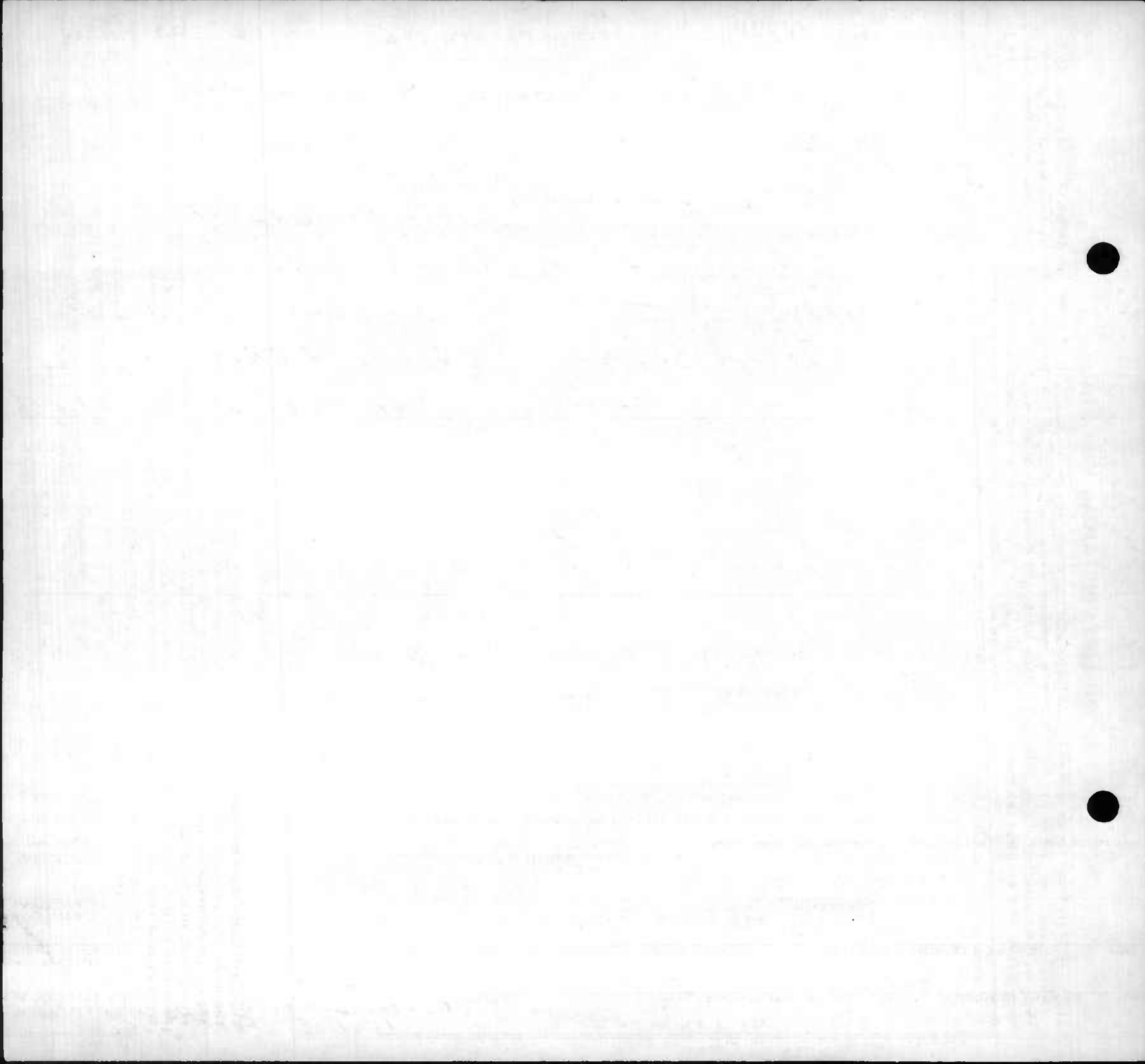
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0959				
BIRTH NO. 65 0959									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		ANDREWS, WILLIAM FREDERICK			2. DATE AND HOUR OF DEATH		1-25-65 11:20 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL					A. STATE MARYLAND COUNTY 15-13				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 4311 REISTERSTOWN RD. 15				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED		8. DATE OF BIRTH 10-18-98		9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Self employed - Tire Repair and Recapping		Repair and Recapping		Baltimore County, Md.			U.S.A.		
13. FATHER'S NAME CHARLES Andrews				14. MOTHER'S MAIDEN NAME CAROLYN Hahn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. 213-03-5451A		17. INFORMANT Mrs. Lydia N. Andrews			
				18. CAUSE OF DEATH		ADDRESS 4311 Reisterstown Rd. Baltimore, Md. 21215			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Carcinomatous		INTERVAL BETWEEN ONSET AND DEATH			
				(B) DUE TO Ca of Prostate					
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-4- 19 64 to 1-25- 19 65 , that (I) (we) last saw the deceased alive on 1-25- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE EDILBERTO BELTRAN					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type) Edilberto R. Beltran					23D. ADDRESS ST AGNES HOSPITAL, BALTO. 29, MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/1965		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm. J. Jackson & Sons		ADDRESS Baltimore, Md. North & Cal. Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0960		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 0960	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Christina P. Golosewski</i>			
2. DATE AND HOUR OF DEATH		<i>Jan. 23, 1965</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2401</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>1412 Keyhole St.</i>		9. AGE (In years last birthday) <i>58</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb. 16, 1906</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Char Lady</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Joseph Sperry</i>		14. MOTHER'S MAIDEN NAME <i>Maryanna Antkiewicz</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-01-5231</i>		17. INFORMANT <i>Christina Gregorak 1344 Andre St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Occlusion Immediate</i>		CAUSE OF DEATH (A) DUE TO <i>Arterio-sclerotic Heart Disease 3-4 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>(2)</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Elliptotes Mellitus</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/14</i> 19 <i>61</i> to <i>1/23</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>1/15</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harry Deibel</i> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/26/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. HARRY DEIBEL</i>		23D. ADDRESS <i>1226 Hanover St Baltimore Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/27/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i>			
25D. ADDRESS <i>1501 E. Fort Ave.</i>					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES RITTENHOUSE ULLRICH

~~JAMES RITTENHOUSE~~

2. DATE AND HOUR PRONOUNCED DEAD

1-25-65

8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 W. Monument Street - 21201

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single

8. DATE OF BIRTH

5-26-08

9. AGE (in years
last birthday)

56

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Floor Manager

10B. KIND OF BUSINESS OR INDUSTRY

Department Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

J. Harry Ullrich, M.D.

14. MOTHER'S MAIDEN NAME

Sarah Rittenhouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-16-6760

17. INFORMANT

ADDRESS

Mr. Charles K. Rittenhouse-1300 Francis Ave-27

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~xxxxxxx~~ Massive cerebellar hemorrhage, left,
fresh

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1-25-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-27-65

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 27 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard-4107 Wilkens Ave-21229

VALLEY FORCE

Next 02

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-3501		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0962	
BIRTH NO. 65 0962		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Weedon, John		2. DATE AND HOUR OF DEATH 1-23-65 11:55 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 2-2-65 HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX Male		6. RACE white		7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	
8. DATE OF BIRTH 6-16-91-1901		9. AGE (In years last birthday) 63		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John L. Weedon		14. MOTHER'S MAIDEN NAME Ethel Foster		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-6389		17. INFORMANT ADDRESS Mrs. Mary T. Weedon-2110 Alletta Ave-21227	
18. CAUSE OF DEATH 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) urina and anuria ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, pneumonia ? P.V.A.		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-21-1965 to 1-23-1965 , that (I) last saw the deceased alive on 1-23-1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE S. Siros		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-23-65	
23C. PHYSICIAN'S NAME (Type) Siroos Gerami		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-65		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229	

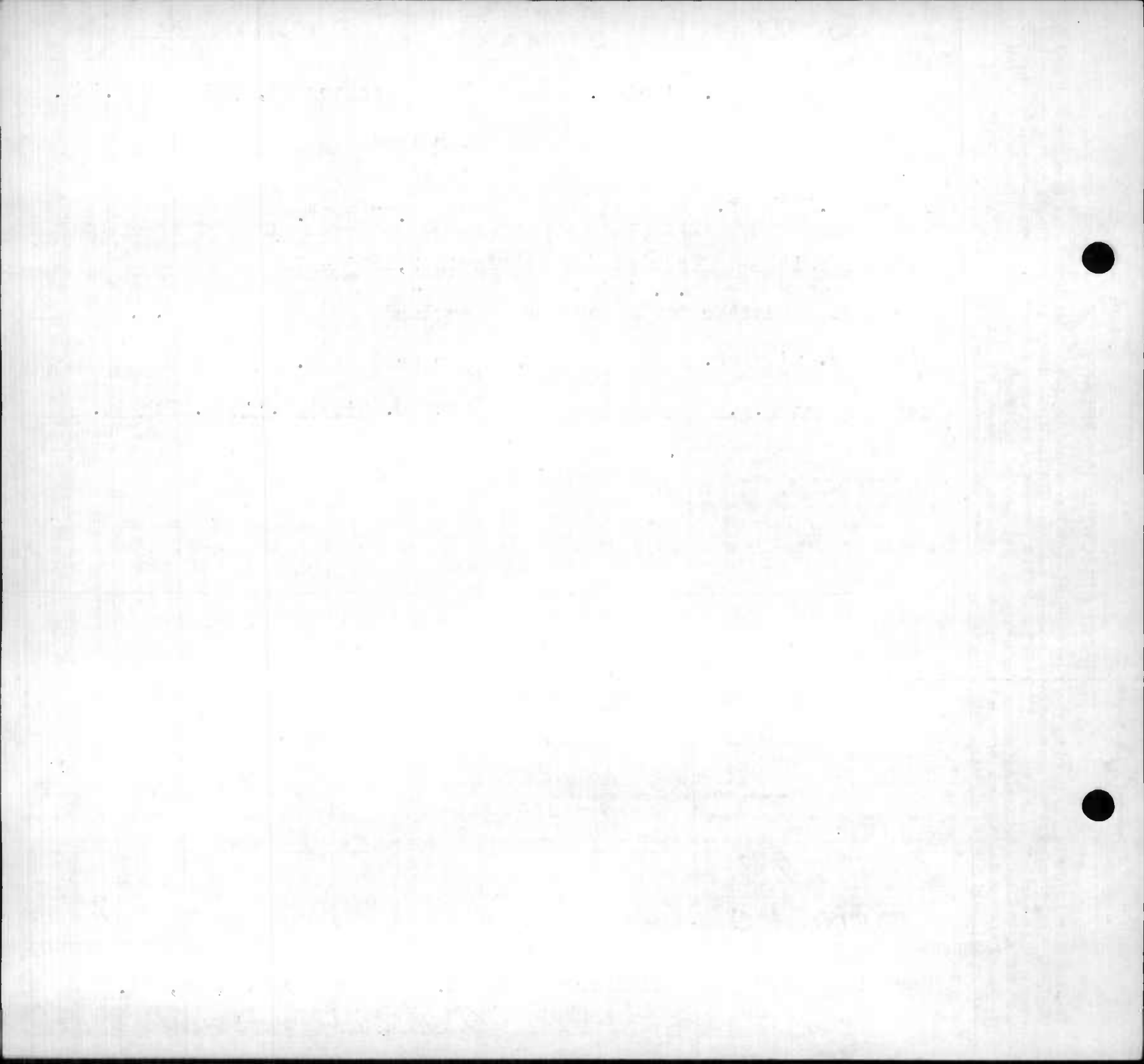
Birth Certificate B-18524 - 1901
M.H. 2-2-65

B-18524
1961

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0963	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0963					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
James H. O'Brien.		January 25, 1965 6:55A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 502 W.27th St.		A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 502 W.27th St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 2, 1893	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tool Dresser		10B. KIND OF BUSINESS OR INDUSTRY Steel Erection		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James H. O'Brien.		14. MOTHER'S MAIDEN NAME Margaret Sapp.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 1st W.W.		17. INFORMANT Retta W. O'Brien.	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of the lung DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 7 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-30 1964 to 1-25 1965, that (I) (we) last saw the deceased alive on 1-24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Alfred G. Ossman Jr		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-26-65	
23C. PHYSICIAN'S NAME Alfred G. Ossman Jr		23D. ADDRESS 1010 St Paul St Balt 2 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/65		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Frederick Road, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.		25C. FUNERAL DIRECTOR Austin E. Donovan	
				ADDRESS 3818 Roland Ave	

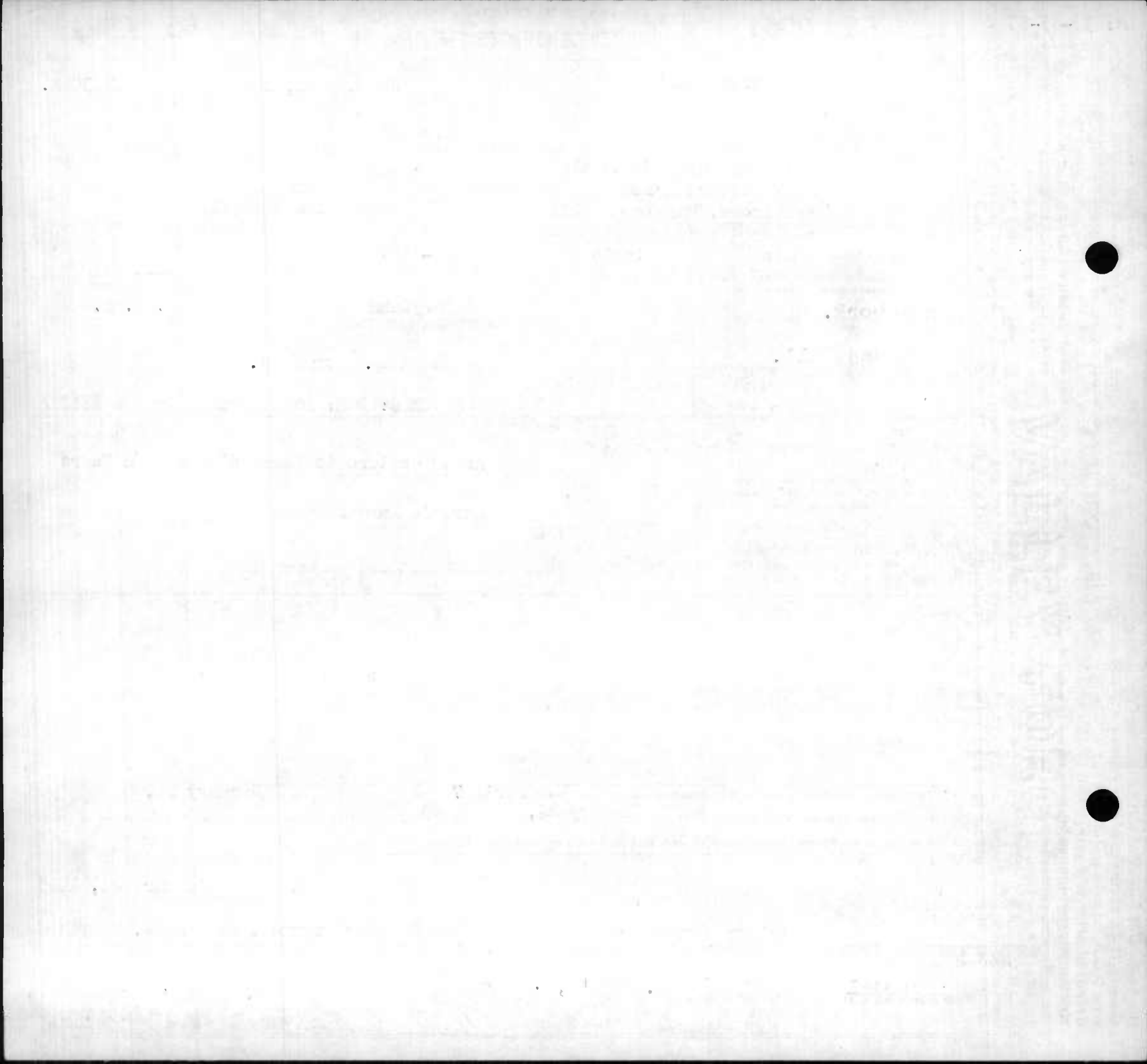


LS: 36-85-83
14-400-83

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

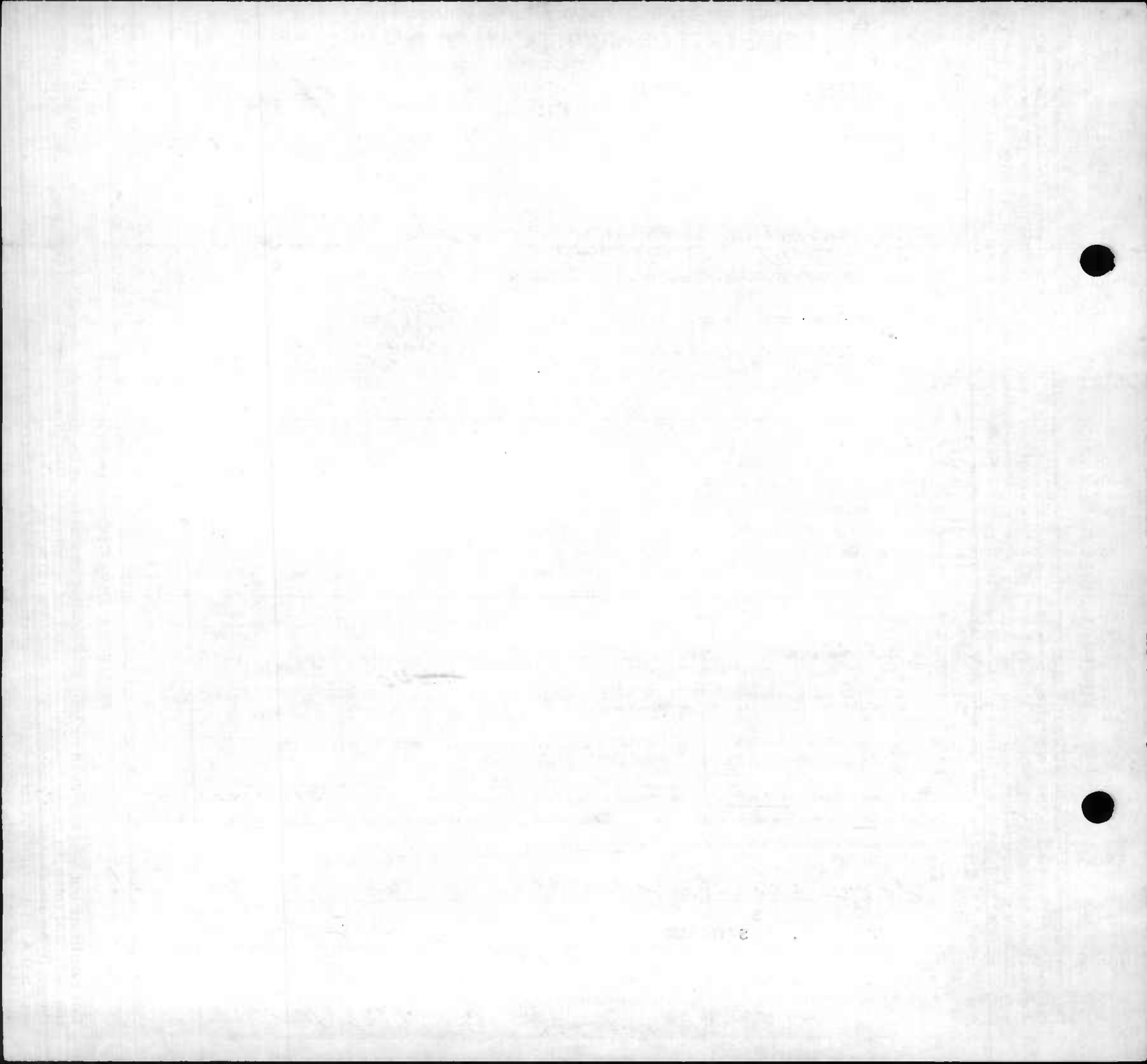
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 0964	
BIRTH NO. 65 0964										M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Roberta Hill					2. DATE AND HOUR OF DEATH January 24, 1965 12:30 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-01						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location Baltimore City Hosptials 4940 Eastern Avenue Baltimore, Maryland 21224					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore						
D. STREET ADDRESS (If rural, give location) 2401 Eutaw Place #21217											
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 4-4-1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Alfred Hill.					14. MOTHER'S MAIDEN NAME Emma L. Burkins.						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. no		17. INFORMATION ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.0 I Arteriosclerotic Heart Disease 2 Years					CAUSE OF DEATH (A) DUE TO Chronic Lung Disease (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from April 7 19 64 to January 24 , 19 65 , that (I) (we) last saw the deceased alive on January 24 , 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Julius Krevans M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED January 24, 1965			
23C. PHYSICIAN'S NAME (Type) Julius Krevans M.D.					23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/27/65		24C. NAME of CEMETERY or CREMATORY St. Mary's, Hampden			24D. LOCATION (City, town, or county) (State) 3900 Roland Ave, Balto Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965			25B. NAME OF REGISTRAR Robert E. Taylor M.D.			25C. FUNERAL DIRECTOR ADDRESS Quentin E. Donovan-3818 Roland Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

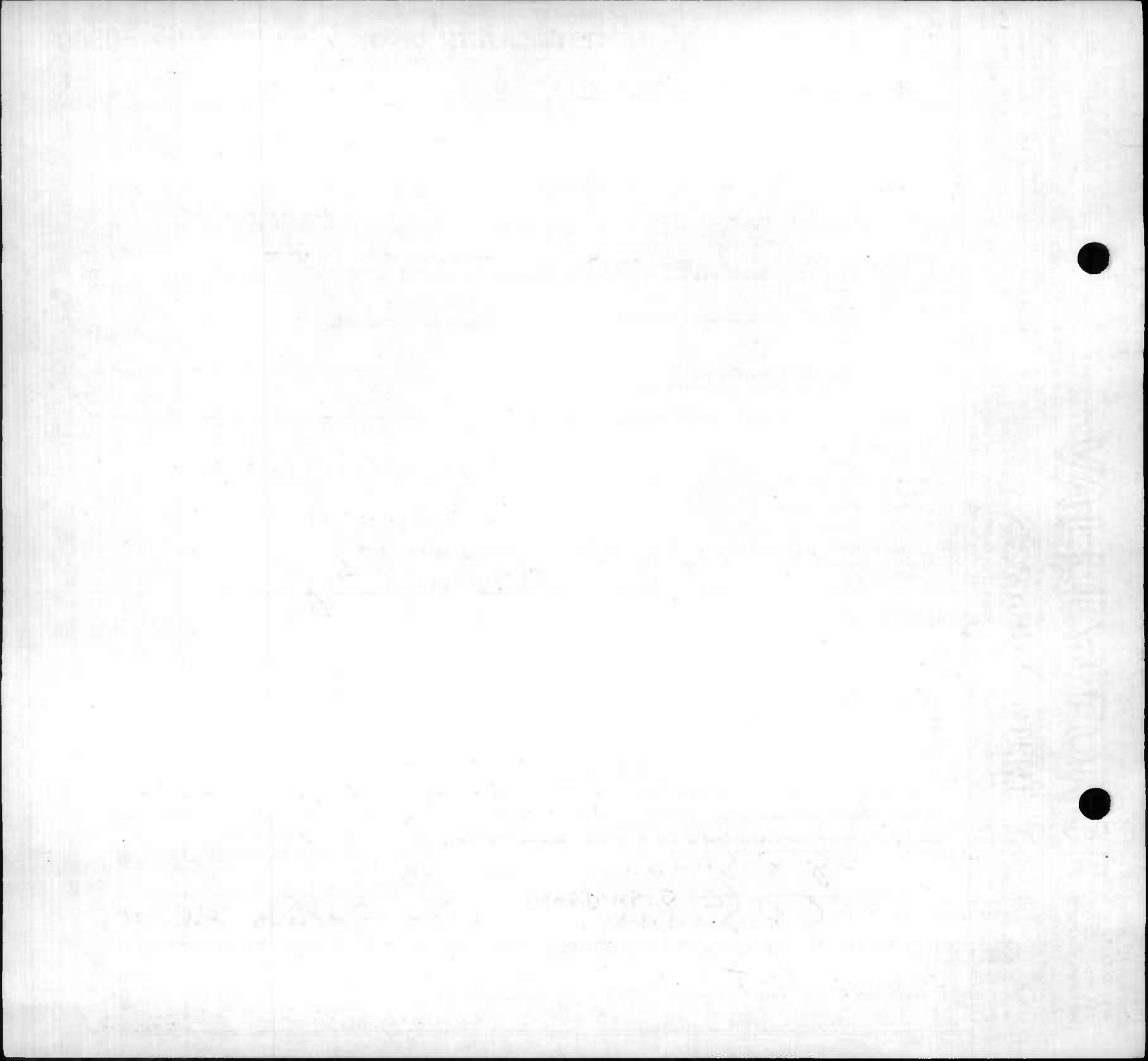
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0965	
BIRTH NO. 65 0965				CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BRESNICK, VICTOR			2. DATE AND HOUR OF DEATH January 24, 1965 5:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6104 Spruwood Ct.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/28/88	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bracklayers		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Victor Bresnick			14. MOTHER'S MAIDEN NAME Matilda Gorup		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-0032 A	17. INFORMANT Hospital Records ADDRESS		
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinoma of the lung ~ 10 mos. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Dec. 4 19 64 to Jan. 24 19 65 , that (I) (we) last saw the deceased alive on Jan. 24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry N. Rosenbaum M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/24/65
23C. PHYSICIAN'S NAME (Type) S Barry N. Rosenbaum			23D. ADDRESS University Hospital M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-27-65	24C. NAME OF CEMETERY or CREMATORY Zion Lutheran		24D. LOCATION (City, town, or county) Balto. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Connelly ADDRESS 340 Meade Ave. Balto. 21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

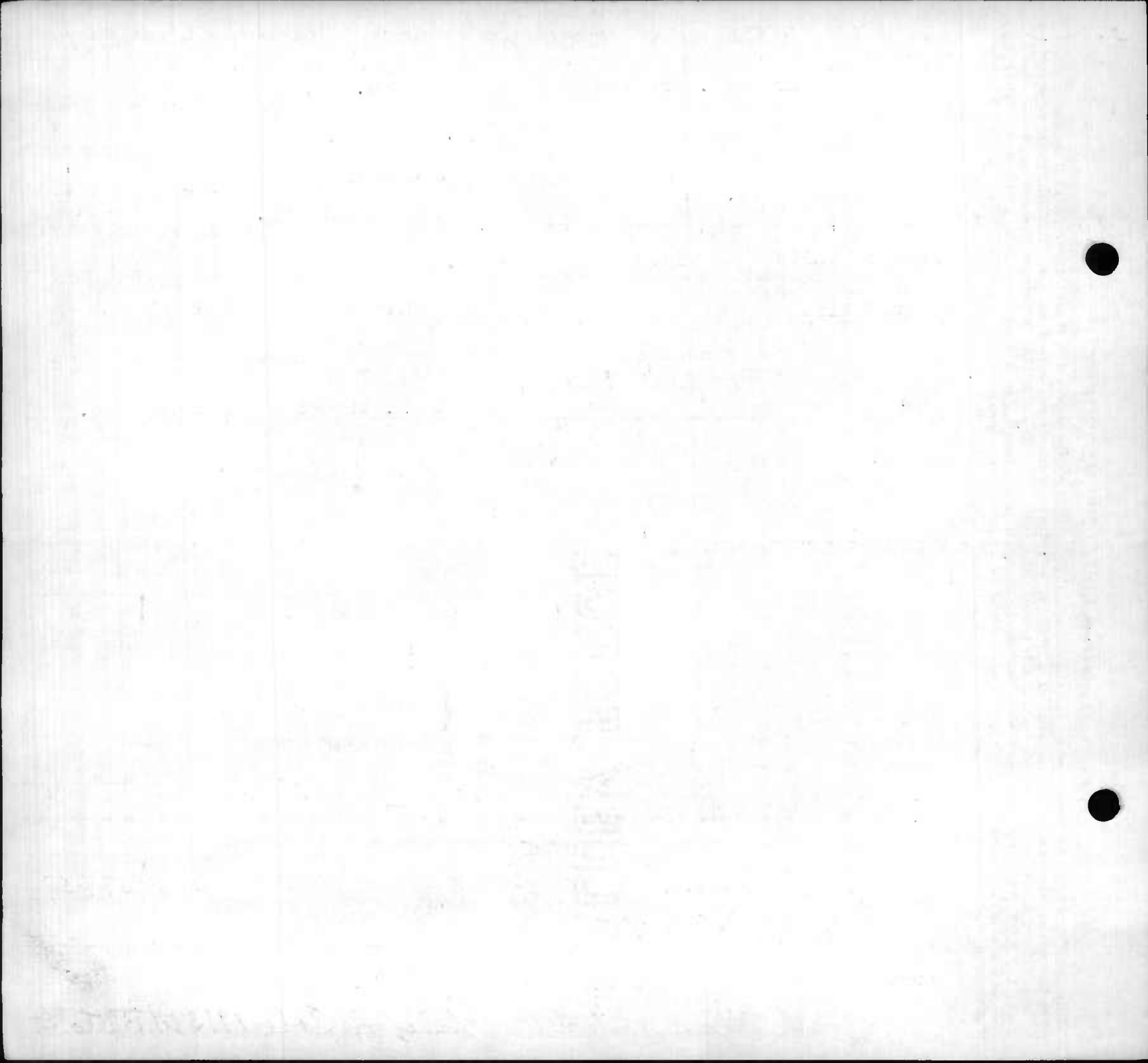
BIRTH NO. 65 0966				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0966	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				WILLIAM H ROZIER		Jan. 24, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY			
(If not in hospital or institution, give street address or location)				Md. Balto. Balto					
90 Gould Nursing Home				C. CITY OR TOWN		(If outside city limits, write RURAL and give township)			
6116 Belair Rd.				D. STREET ADDRESS		(If rural, give location)			
				525 Sandbarwood Rd.		SANDALWOOD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Male	White	Single	12-31-81	83	Laborer	Balto.	U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
					Mm. Charles 7581C		123123		
18. 443X I				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				"Hypertensive					
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				Cardio-vascular					
				(C) DUE TO					
				Semi-lity					
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work							
22. I certify that (I) (this hospital) attended the deceased from 1-11-1965 to 1-23-1965, that (I) (we) last saw the deceased alive on 1-23-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
G. R. SAGADI									
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
G. R. SAGADI				5829 Belair Rd #6					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION		(City, town, or county) (State)	
Burial		1-27-65		Oak Lawn Cemetery		Balto, Co.		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
JAN 27 1965		Robert E. Taylor, M.D.		Connelly, J. J.		300 Main Ave.		Balto. 21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 0967</u>	
BIRTH NO. <u>65 0967</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Martha H. Grosch.</u>		2. DATE AND HOUR OF DEATH <u>Jan. 23, 1965</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4920 Curtis Ave.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2505</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4920 Curtis Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 1, 1870</u>	9. AGE (In years last birthday) <u>94</u>	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>Unknown</u>				
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Alberta M. Thomas 4920 Curtis Ave.</u>				
18. <u>490X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Acute pneumonia.</u> (B) <u>uremia-</u> (C) _____ INTERVAL BETWEEN ONSET AND DEATH				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> 19 <u>65</u> to <u>Jan 23</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>Jan 23</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Y. K. YUAN</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan 25, 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Y. K. YUAN</u>				23D. ADDRESS <u>Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>JAN 27 1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Fred A. Cole</u>		ADDRESS <u>1913 W. Balto. St</u>	



B-600

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. BARROW

2. DATE AND HOUR PRONOUNCED DEAD

January 23, 1965 12:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

312 E. 28th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Oct. 2, 1899

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3 21

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Repair

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Capon Bridge, W. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Milton Barrow

14. MOTHER'S MAIDEN NAME

Sarah E.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes 1

W W 1 & 2

16. SOCIAL
SECURITY NO.

216-10-1958

17. INFORMANT

ADDRESS

Marie A. Barrow 3912 Southclaire Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 27/1965

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JAN 27 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Fred A. Cole

ADDRESS

1913 W. Balto. St

VALLEY FIDUCIARY

REGISTERED

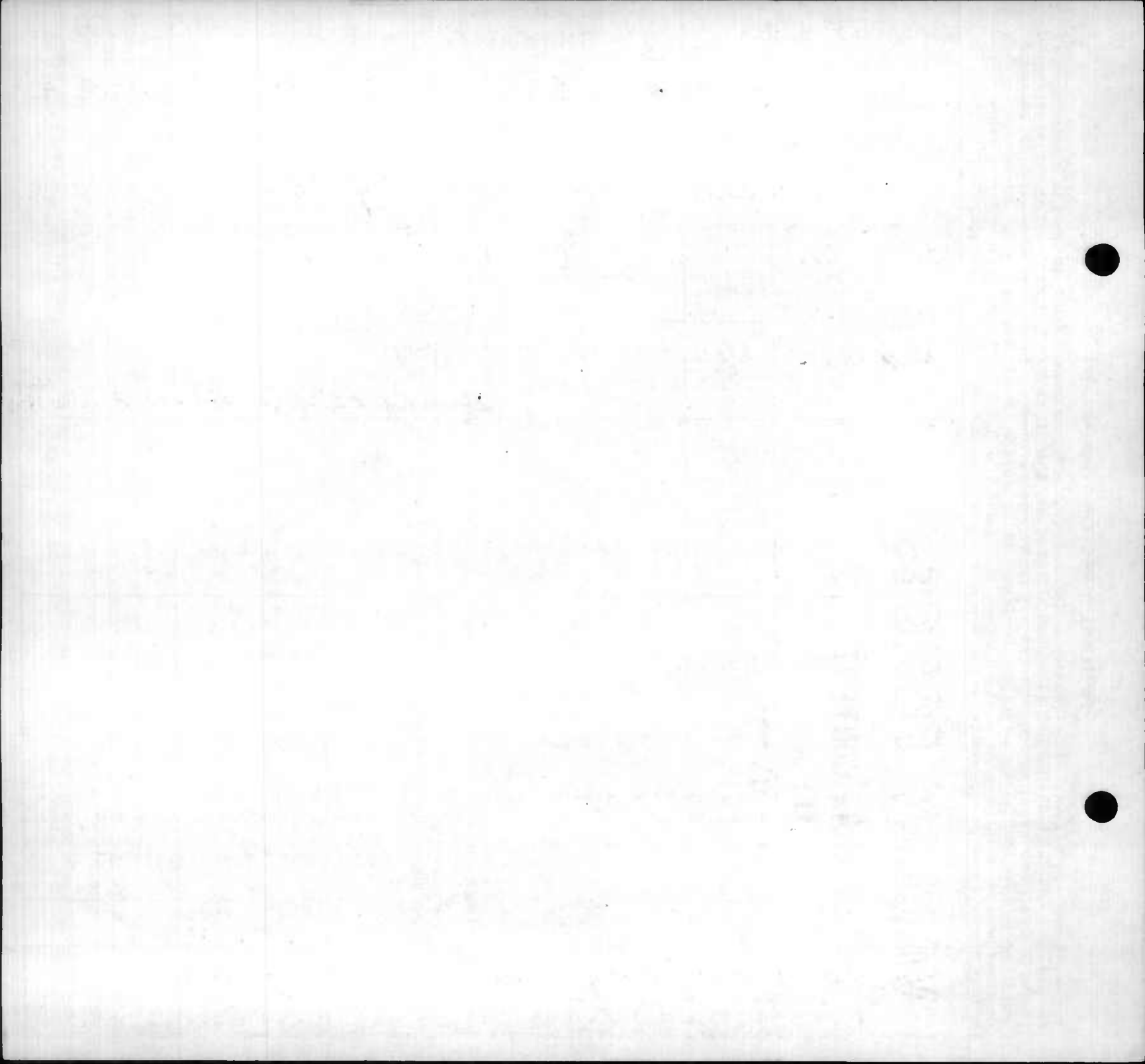
[Handwritten signature]

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

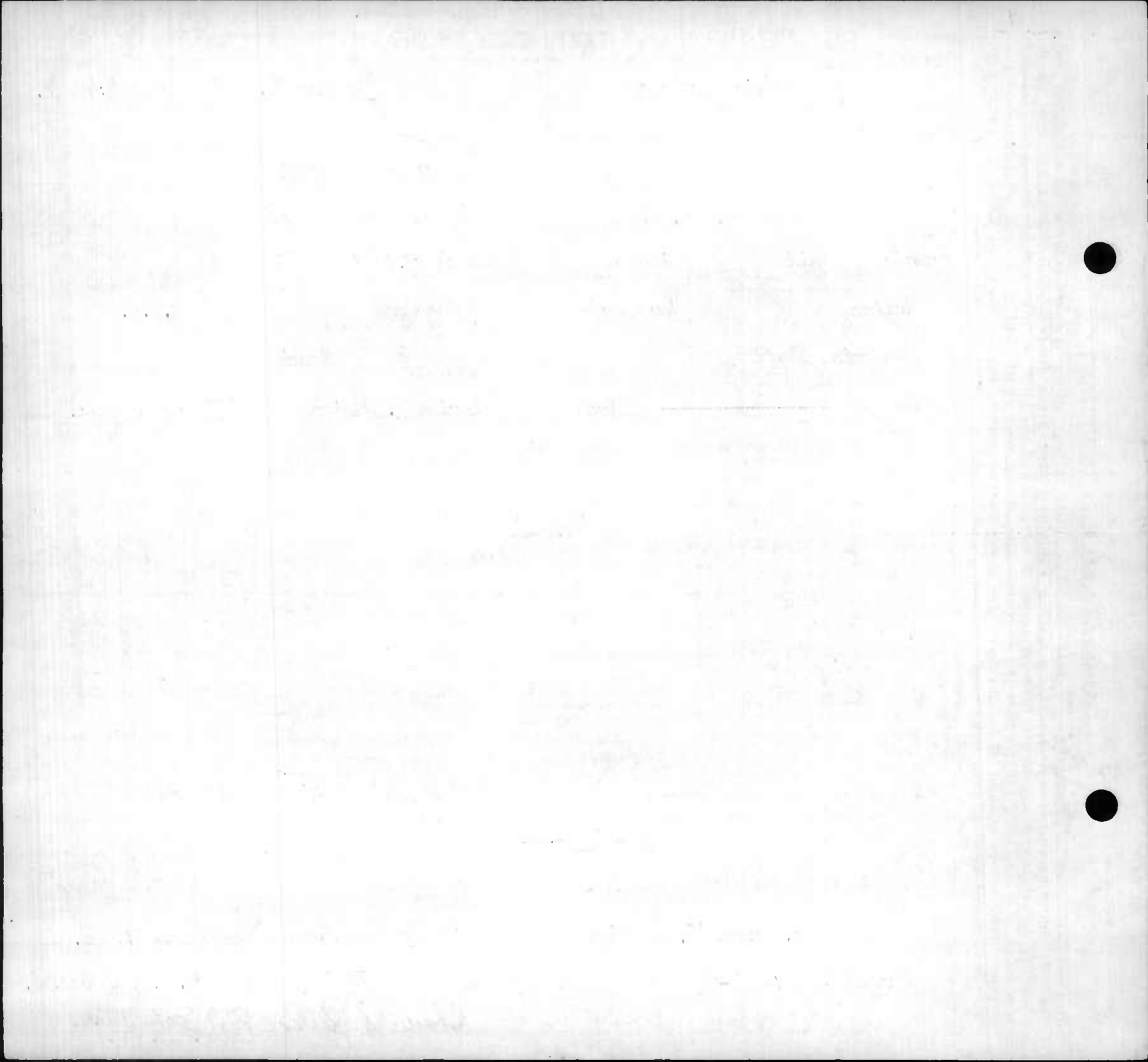
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0969	
BIRTH NO. 65 0969				CERTIFICATE OF DEATH	
M.E. CASE NO. 5				1. NAME OF DECEASED (Type or Print) EVA STYCZEWSKI	
2. DATE AND HOUR OF DEATH Jan. 26, 1965 10-10 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 4703 Fairhaven Ave. Zone 26				A. STATE Md. B. COUNTY 25-05	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. City	
				D. STREET ADDRESS (If rural, give location) 4703 FAIRHAVEN AVE.	
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Dec 22, 1996	9. AGE (In years, last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Alexander Slowikowski			14. MOTHER'S MAIDEN NAME anna -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Stanislaw Styczewski ADDRESS 4703 Fairhaven Ave.
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) arteriosclerosis Heart disease			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		(B) DUE TO
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Cerebral Hemorrhage		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Oct 15 1964 to Jan 26 1965 , that (I) (we) last saw the deceased alive on 1/25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Rubin M.D.				23B. DATE SIGNED 1/26/65	
23C. PHYSICIAN'S NAME (Type) Samuel Rubin				23D. ADDRESS 203 Patapsco Avenue Baltimore, Md. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-30-65	24C. NAME OF CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) A.A. Co. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2007 Eastern Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

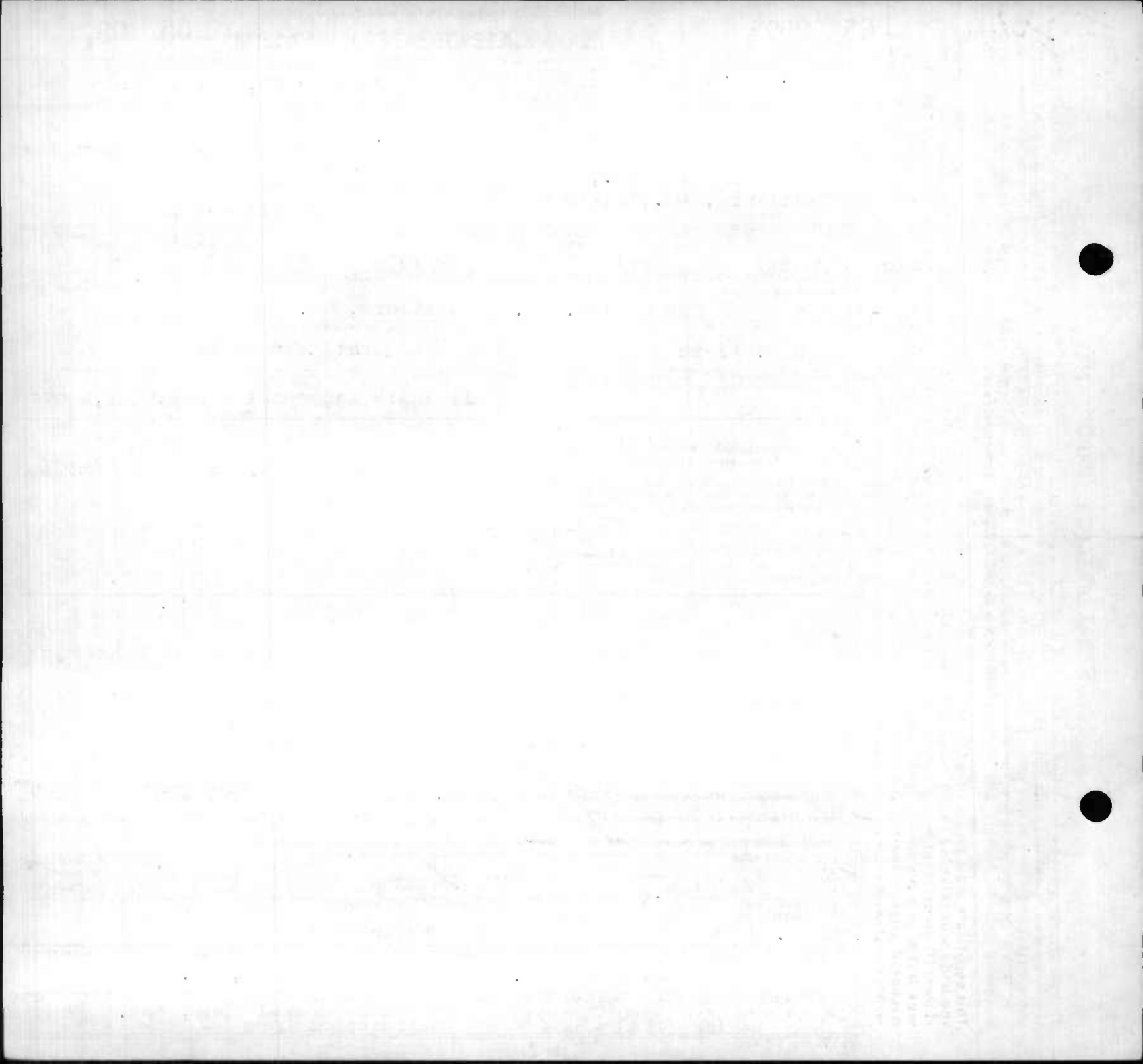
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0970	
BIRTH NO. 65 0970		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<i>Mollie Luckner</i>		<i>January 24, 1965 4:40 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE		
			B. COUNTY		
<i>433 Angelsea Street Baltimore, Md. 21224</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location)		
			<i>Maryland</i>		
			<i>Baltimore # 21224</i>		
			<i>433 Angelsea Street</i>		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>March 23, 1881</i>	<i>83</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Retired</i>		<i>Housework</i>		<i>Maryland</i>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<i>Benjamin Shott</i>			<i>? Resch</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>No</i>		<i>None</i>		<i>Louise E. Ulrich</i>	
				<i>433 Angelsea St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		<i>3 hours</i>
			(B) DUE TO		<i>9 years</i>
			(C) DUE TO		<i>Several years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<i>Circulatory failure</i>		
			<i>Hypertensive Cardio-vascular disease</i>		
			<i>Generalized arteriosclerosis</i>		
			<i>Senile psychosis (institutional)</i>		<i>1 year</i>
			<i>Malnutrition</i>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<i>0</i>		<i>—</i>		<i>—</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<i>—</i>		<i>—</i>		<i>—</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
<i>—</i>		<i>White At Work</i>		<i>—</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>July 1-24 1965</i> to <i>1-24 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Eugene C. Baumann</i>				<i>1-26-65</i>	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
<i>Dr. Eugene C. Baumann</i>			<i>413 Eastern Avenue Baltimore 21, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Burial</i>		<i>1-27-65</i>		<i>Oak Lawn Cemetery</i>	
				<i>7225 Eastern Blvd. Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<i>JAN 27 1965</i>		<i>Robert E. Fisher</i>		<i>Charles L. Zeiler</i>	
				<i>6224 Eastern Ave. Balto. 24, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

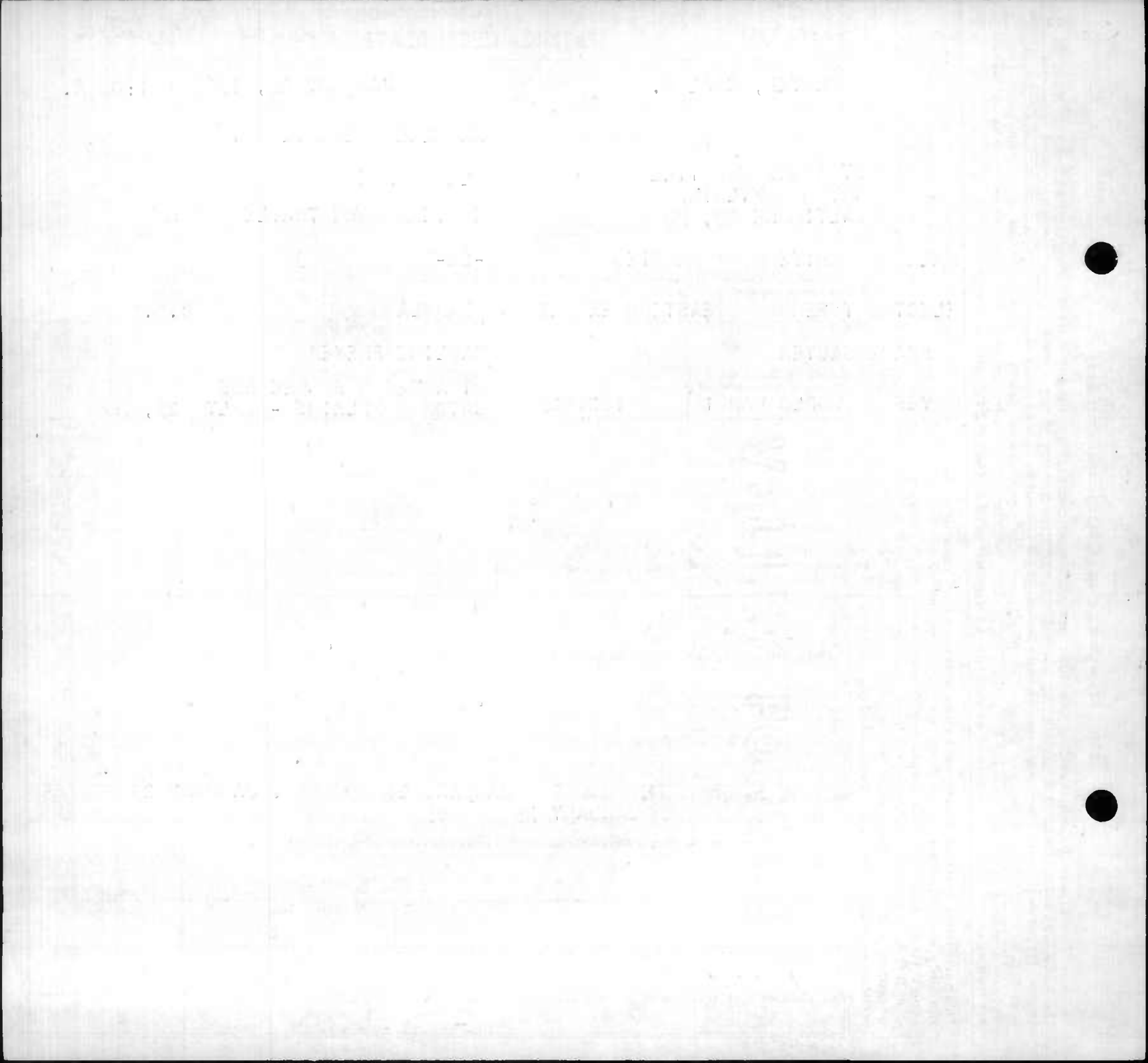
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>65 0971</u>					
BIRTH NO. <u>65 0971</u>		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>JOHN WILLIAM FISSE</u>			2. DATE AND HOUR OF DEATH <u>January 25, 1965</u> <u>12:45</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>8-01</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2818 Mayfield Ave., Baltimore, Md., 21213</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
					D. STREET ADDRESS (If rural, give location) <u>2818 Mayfield Avenue</u>					
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>9/23/1879</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe-fitter</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Gas & Elec. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>John W. Fisse</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Amenhauser</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Elizabeth Nagengast Fisse, wife, above</u>					
18. <u>157X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Admo Carcinoma of pancreas</u> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>										
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>20 years</u> 19 <u>45</u> to <u>Jan 25</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan 24</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <u>James E. White</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/26/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. James E. White</u>					23D. ADDRESS M.D. <u>5214 Harford Road</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/28/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Mem. Park</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>			25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0972	
BIRTH NO. 65 0972		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) SAUTER, CARL F.		JANUARY 25, 1965 1:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON & WILKINS BALTIMORE 29, MD		A. STATE B. COUNTY XXXXXXXXX PENNSYLVANIA V-35 C. CITY OR TOWN (If outside city limits, write RURAL and give township) LANGHORNE D. STREET ADDRESS (If rural, give location) EASTERN DAWN TRAILER PARK			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-22-95	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRO TYPER		10B. KIND OF BUSINESS OR INDUSTRY EASTERN EXPRESS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME FRANZ SAUTER			
14. MOTHER'S MAIDEN NAME PAULINE FREYER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 1			
16. SOCIAL SECURITY NO. 182102393		17. INFORMANT ST AGNES HOSP RECORDS CATON & WILKINS - BALTO 29, MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 4 days A.S.C.V.D. several yrs		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 21 19 65 to JANUARY 25 19 65, that (I) (we) last saw the deceased alive on JANUARY 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE F. D. Darcy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type) F. D. Darcy		23D. ADDRESS St Agnes Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/1965		24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT. Cem.	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 27 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR G. Trumbull Schwab			
ADDRESS 3512 FREDERICK AVE. (29)					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

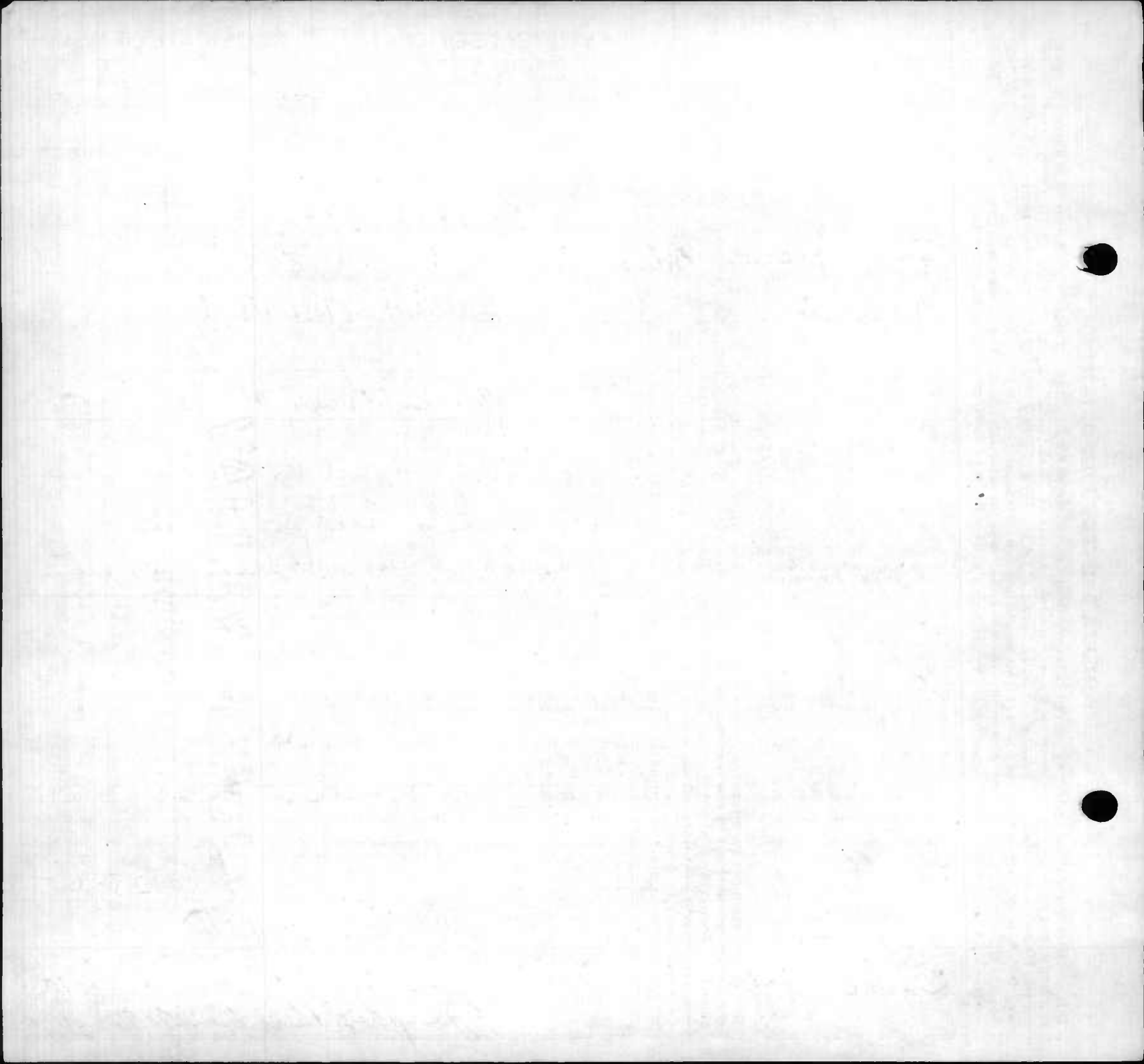
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0973	
BIRTH NO. 65 0973				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Hattie Holiday</u>				1-24-65 10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1404 McCulloh Street</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-29-?</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Holiday</u>			14. MOTHER'S MAIDEN NAME <u>Clara Brown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>714-14-0792</u>		
17. INFORMANT <u>Bessie Samson</u>			ADDRESS <u>1404 McCulloh St.</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarct</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary heart Disease</u> <u>Atherosclerosis</u>			<u>2 years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-24-65</u> 19 to <u>1-24-65</u> 19, that (I) (we) last saw the deceased alive on <u>1-24-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alvin Thompson</u>				23B. DATE SIGNED <u>1-25-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alvin Thompson</u>				23D. ADDRESS <u>1514 Division Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/28/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Park</u>	
24D. LOCATION <u>Arbutus (Baltimore) Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1965</u>		24F. NAME OF REGISTRAR <u>Robert E. Farley</u>	
24G. FUNERAL DIRECTOR <u>Joseph L. Russ</u>		24H. ADDRESS <u>2222 W. North Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 0974		65 0974	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				DORA ADKINS		JAN - 25, 1965 9:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
1515 N. BRUCE ST				MD 15-02			
5. SEX F				6. RACE NEGR.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Housewife		?		?		80?	
13. FATHER'S NAME				11. BIRTHPLACE (State or foreign country)			
				Baltimore, Maryland			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						Mrs. Elsie Wesley 4131 Tawman Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 7, 1965 to Jan 24, 1965, that (I) (we) lost saw the deceased alive on Jan 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Geo. H. Pendleton M.D.						23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
GEO. H. PENDLETON M.D.				1723 Druid Hill Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/30/65		Mt. Auburn Cern.		Westport (Baltimore) Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 27 1965		Robert E. Fisher M.D.		Joseph L. Russ		2222 W. North Ave.	



1

65 0975

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 0975

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **EARY JENKINS**

2. DATE AND HOUR PRONOUNCED DEAD **January 27, 1965 3:59 a.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland**

B. COUNTY **Baltimore**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **2732 Biddle St.**

5. SEX **female**

6. RACE **colored**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Single**

8. DATE OF BIRTH **January 18, 1911**

9. AGE (in years last birthday) **54**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**

11. KIND OF BUSINESS OR INDUSTRY **Baltimore Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Henry Jenkins**

14. MOTHER'S MAIDEN NAME **Ruth Taylor**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO.

17. INFORMANT **James Jenkins**

ADDRESS **2732 E. Biddle St.**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) **Carcinoma of the colon with metastases**

DUE TO

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Rudiger Breiteneker**

EXAMINER'S NAME (Type) **Rudiger Breiteneker**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **1-27-65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

23B. DATE **Jan 30/65**

23C. NAME OF CEMETERY or CREMATORY **Mt Auburn Cemetery**

23D. LOCATION (City, town, or county) (State) **Westport Md**

24A. DATE REC'D BY HEALTH DEPT. **JAN 27 1965**

24B. NAME OF REGISTRAR **Robert E. Farley, M.D.**

24C. FUNERAL DIRECTOR **Frank E. Erickson**

ADDRESS **1129 N. Caroline St**

VS 151-REV. 1/1/65

WALLACE POLICE

RECEIVED

NOV 1

1964

11

NOV 1 1964

1-11-64

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65 0976

BIRTH NO.

65 0976

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JERRID, HARRY

2. DATE AND HOUR OF DEATH

1-18-65

3:55 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

3 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1736 Ashland Ave

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2-21-00

9. AGE (In years
last birthday)

63

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemp. Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Harry Jerrod

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

579-01-0846

17. INFORMANT

John W. Jones 1736 Ashland Ave

ADDRESS

18. 493X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumococcal meningitis
DUE TO

8 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) DUE TO
(C) Pneumococcal pneumonia

8 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1-15-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

TRACHEOSTOMY

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-15 19 65 to 1-18 19 65,
that (I) (we) last saw the deceased alive on 1-18 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John F. Bigger, Jr MD

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-18-65

23C. PHYSICIAN'S
NAME (Type)

JOHN F. BIGGER, JR MD

23D. ADDRESS

M.D. Johns Hopkins Hosp

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

1/21/65

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION

(City, town, or county)

A.A. County Md

25A. DATE REC'D BY HEALTH DEPT

JAN 27 1965

25B. NAME OF REGISTRAR

Robert E. Farley MD

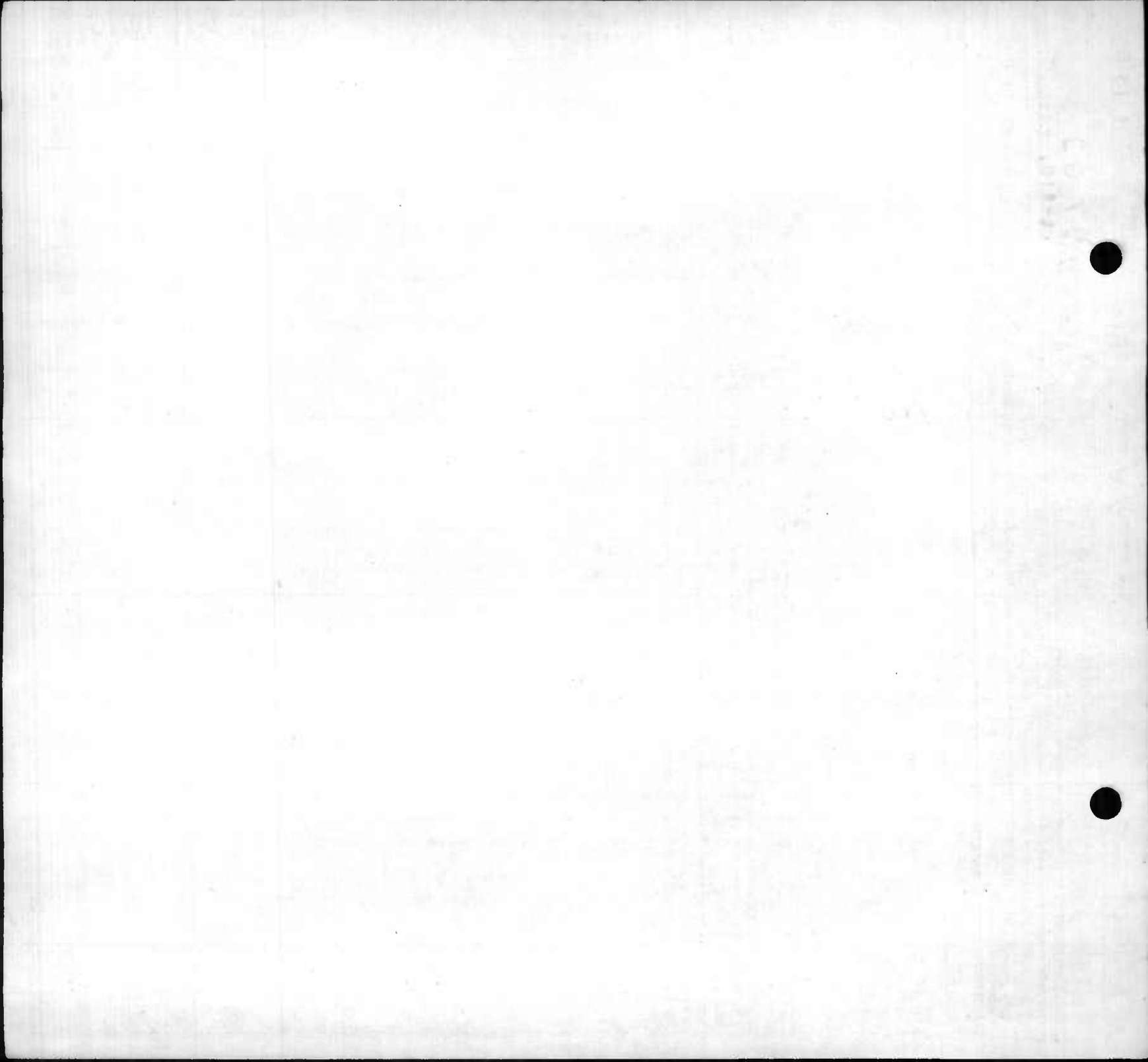
25C. FUNERAL DIRECTOR

Milton E. Elckman 12977 Caroline

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

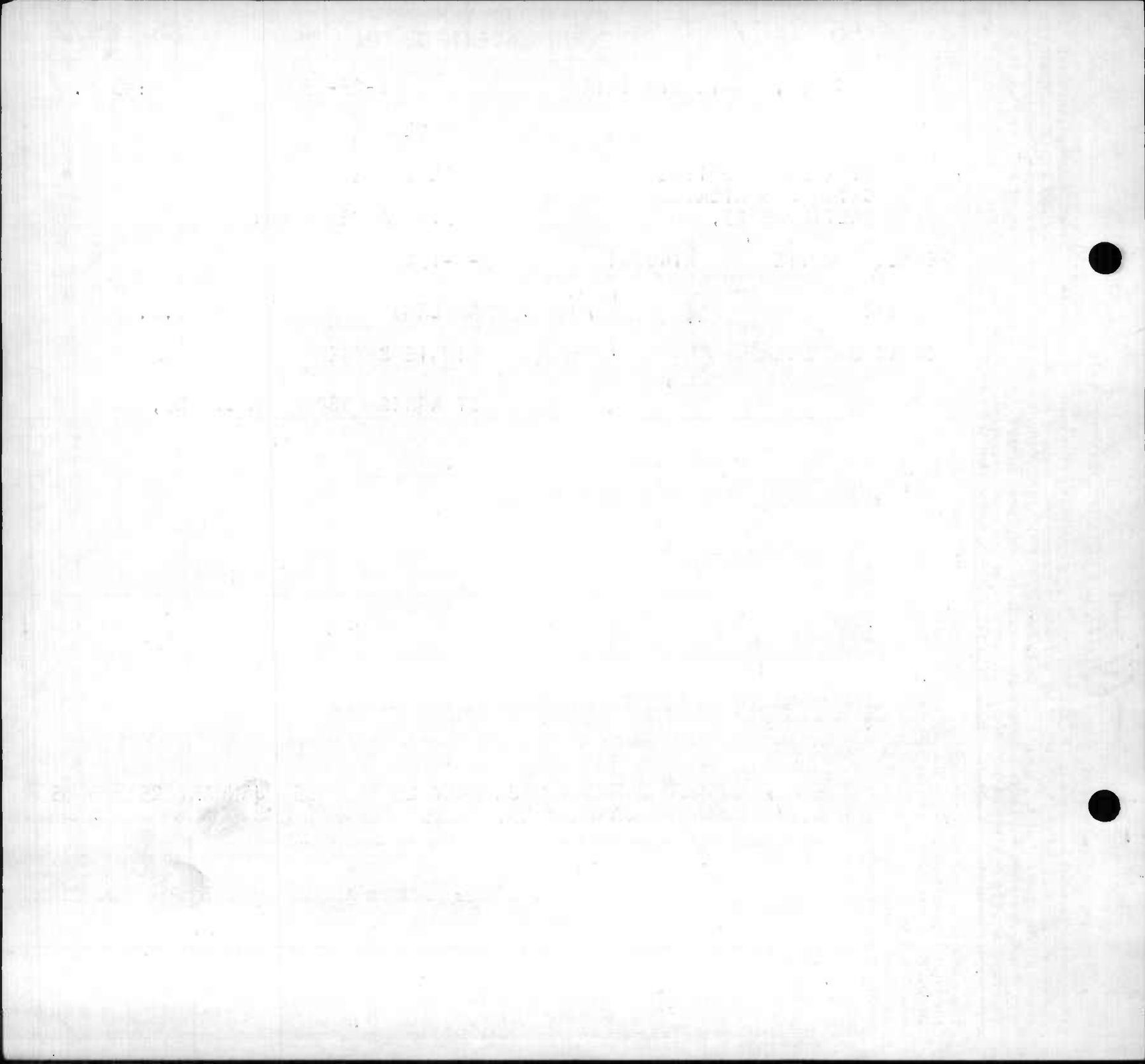
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

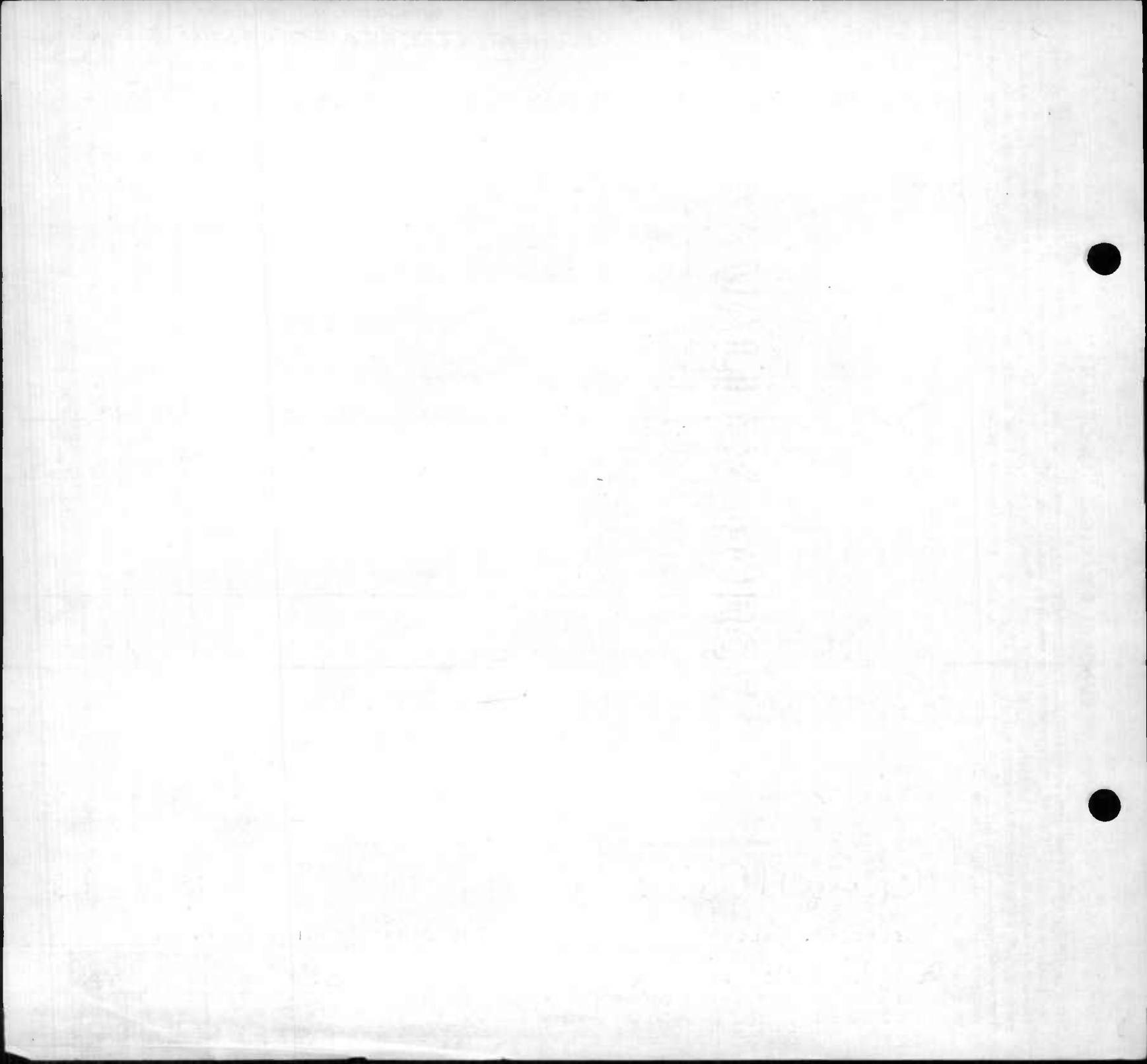
BIRTH NO. 65 0977		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0977	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) MCNAIR, MARIE VIRGINIA			1-25-65 6:43 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON AND WILKINS BALTIMORE 29, MD			A. STATE MARYLAND B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3107 ASPEN COURT		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-6-1909	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY 222-10-4529		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME EDGAR OMOHUNRO - Omohundro			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 222-10-4529		
17. INFORMANT ST AGNES HOSP			ADDRESS BALTO 29, MD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Intracerebral hemorrhage DUE TO (B) Ruptured Cerebral Artery DUE TO (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 22 19 65 to JANUARY 25 19 65, that (I) (we) last saw the deceased alive on JANUARY 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wenfredo N. Iglesias M.D.				23B. DATE SIGNED 1-25-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-28-65		24C. NAME OF CEMETERY or CREMATORY Hood Park Cem. Balto. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Fisher M.D.	
25C. FUNERAL DIRECTOR H. B. Whippert - 1300 E. Main St.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

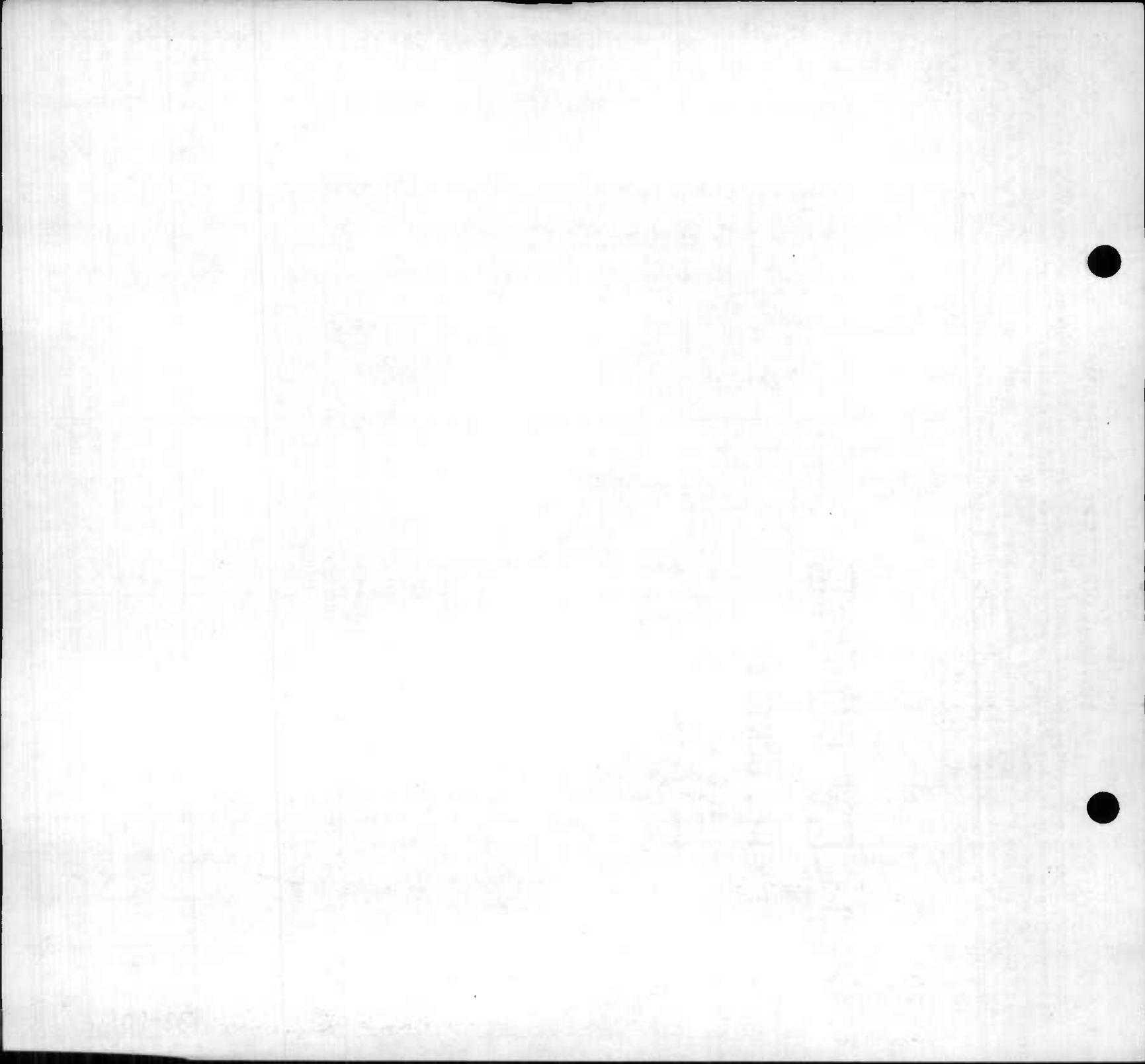
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>112-10-48</u>	
BIRTH NO. <u>65 0978</u>				DATE AND HOUR OF DEATH <u>6:25 Jan 65</u>		M. <u>65 0978</u>	
1. NAME OF DECEASED (Type or Print) <u>RUTH EUENCHICK</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>				A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>3906 GARRISON BLVD</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/28/17</u>		9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Music</u>		11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emanuel Posternak</u>				14. MOTHER'S MAIDEN NAME <u>Mina Nesselstraus</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-40-9889</u>		17. INFORMANT <u>ELIHA EUENCHICK</u>		ADDRESS <u>3906 GARRISON BLVD</u>	
18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of R breast 8 mos</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Carcinoma of R breast 8 mos</u> (B) <u></u> (C) <u></u>			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u></u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>			
22. I certify that <u>1</u> (this hospital) attended the deceased from <u>24 Jan</u> 19 <u>65</u> to <u>25 Jan</u> 19 <u>65</u> , that <u>1</u> (we) last saw the deceased alive on <u>25 Jan</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>1</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>George M Callard</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>25 Jan 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>GEORGE M. CALLARD</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Herring Run</u>		24D. LOCATION (City, town, or county) (State) <u>Balta Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sylvanus S. Lewis</u>		ADDRESS <u>3319 Olympia Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

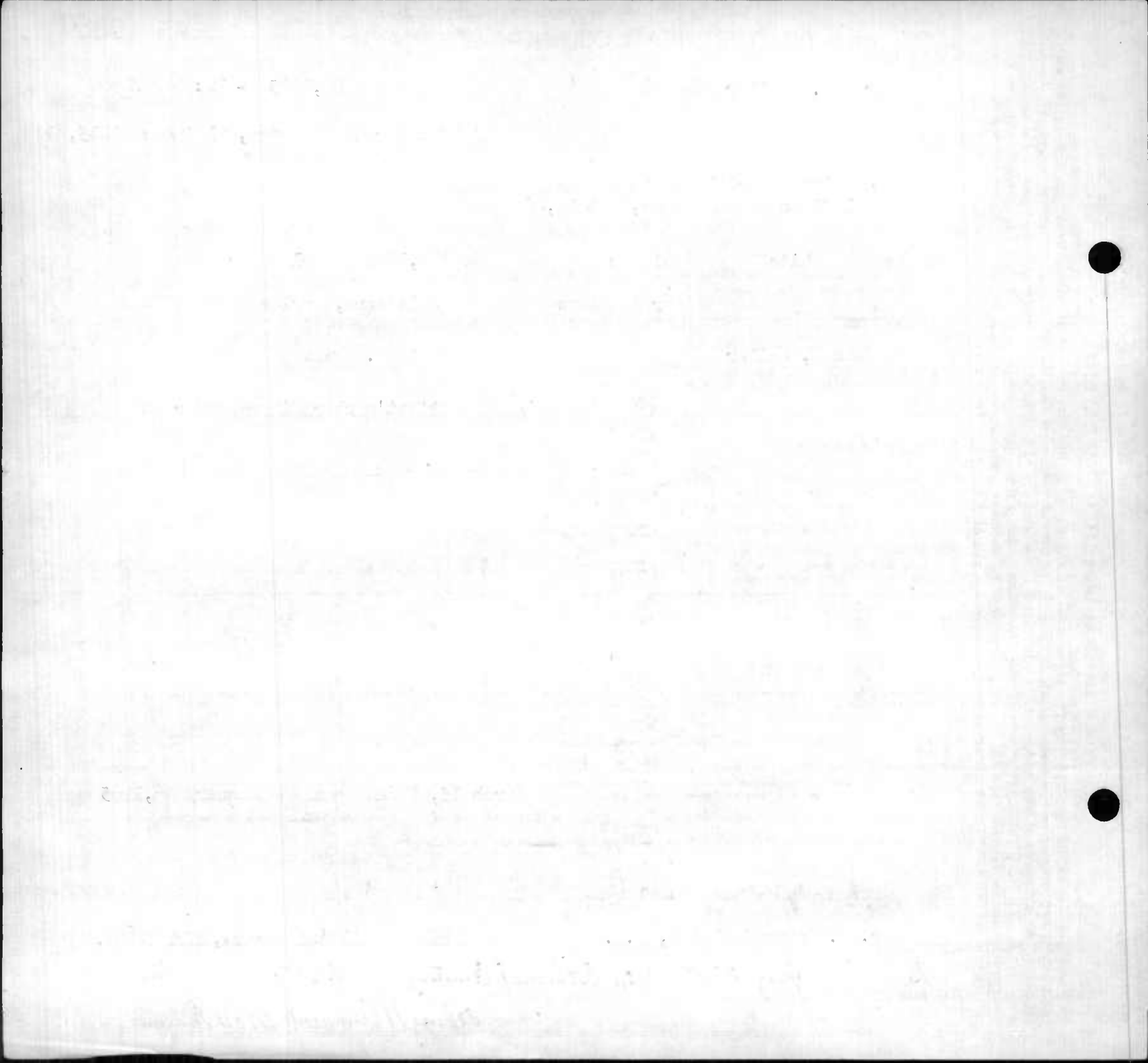
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0979	
BIRTH NO. 65 0979				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ANNA NELSON				1/25/65 16:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. INCORP.		(If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY BALT.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 3314 FAIRVIEW	
5. SEX FEM.	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID	8. DATE OF BIRTH 9/9/98	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANUFACTURIST		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME BARNEY			14. MOTHER'S MAIDEN NAME YETTA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JOSEPH NELSON 3314 FAIRVIEW AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 600.01 Chronic colitis				CAUSE OF DEATH (A) Chronic colitis DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Electrolyte disturbance DUE TO	
				(C) Chronic pyelonephritis	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Heart disease Hypertensive, atherosclerotic					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/12 19 65 to 1/25 19 65 , that (I) (we) last saw the deceased alive on 1/25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harvey A. Levin				23B. DATE SIGNED 1/25/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/27/65		24C. NAME OF CEMETERY OR CREMATORY Rosedale	
Burial				24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS Sylvan S. Lewis & Son 3319 Olympus	



FUNERAL DIRECTOR: IMPORTANT

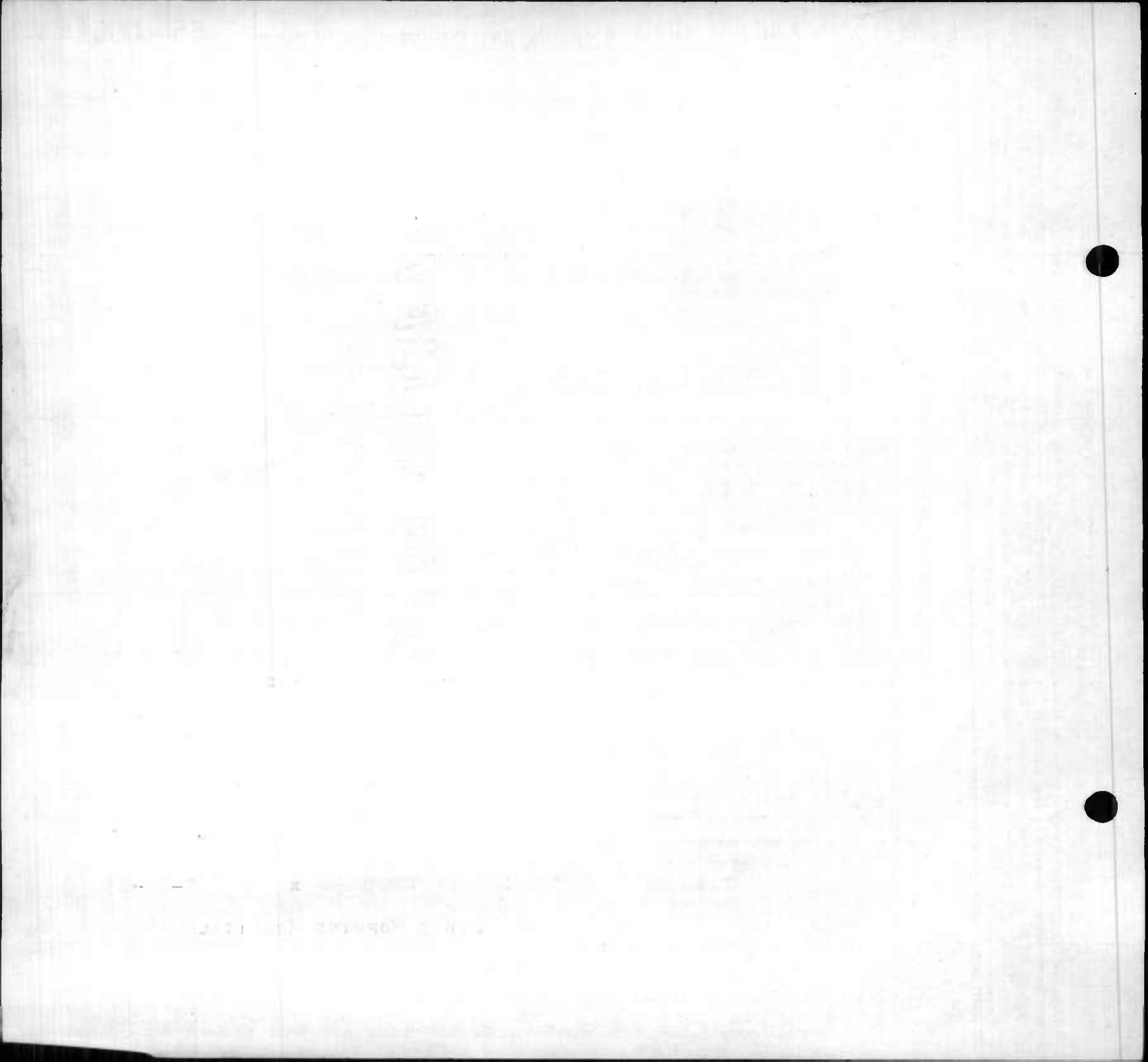
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 0980					CERTIFICATE OF DEATH		Registered No. 65 0980		
1. NAME OF DECEASED (Type or Print) Mary V. Kailer (Miss)					2. DATE AND HOUR OF DEATH Jan 26, 1965 - 12:30 P M				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Jenkins Memorial Hospital 1000 So Caton Avenue, Balt 29, Md					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS 4315 M Fernhill Avenue				
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept 1, 1883	9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY fitter in store		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME John E. Kailer					14. MOTHER'S MAIDEN NAME Julia A. Myers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-C1-9881		17. INFORMANT Patient's chart in record room				
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Pneumonia					INTERVAL BETWEEN ONSET AND DEATH 4 days				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Brain Syndrome									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (the) (this hospital) attended the deceased from March 15, 1962 to January 26, 1965 that (he) (we) last saw the deceased alive on Jan 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Raymond Gladue					23B. DATE SIGNED Jan 26, 1965				
23C. PHYSICIAN'S NAME (Type) Dr. J. Raymond Gladue, M.D.					23D. ADDRESS 3350 Wilkens Avenue, Balt 21229, Md				
24A. BURIAL CREATION, REMOVAL (Specify) Burial		24B. DATE Jan 30/1965		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Henry H. Aronson		25D. ADDRESS 4204 Ridgewood Ave			



THE BODY OF AUSTIN FISHER WAS RELEASED TO THE JOHNS HOPKINS HOSPITAL BY DR. HAUSER OF THE MEDICAL EXAMINER'S OFFICE JANUARY 24, 1965
FUNERAL DIRECTOR: IMPORTANT
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 0981		CERTIFICATE OF DEATH		Registered No. 65 0981	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
AUSTIN FISHER				1-24-65		6.45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND		7-23			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				BALTIMORE CITY					
				D. STREET ADDRESS (If rural, give location)					
				807 N. MADIERA STREET					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
MALE	WHITE	MARRIED	7-26-02	62					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Machinist			Crown Cork & Seal Co		Maryland		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
CHARLES FISHER				MARY ALLEN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No						Mrs. Virginia H. Fisher		807 N. Maderia St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
450.0 I				Generalized arteriosclerosis					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO					
				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 12-16 1964 to 1-6-65 19				that (I) (we) last saw the deceased alive on 1-6-65 19				and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
James F. Fries						1-24-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
James F. Fries				M.D. JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		1/27/65		Meadow Edge Cemetery		Dorsey, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 28 1965		R. E. Fisher, M.D.		Ullrich Funeral Home		4210 Belair Road			



34-83-11

FR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0982

BIRTH NO.

65 0982

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Mildred Olsen - KING.

2. DATE AND HOUR OF DEATH

January 22, 1965 9:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

507 S. Bouldin Street 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3-1-1882

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

HOUSE WORK

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

2 WEEKS

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 5702 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Gangrenous Bowel
DUE TO

2 Days

ANTECEDENT CAUSES

(B) Mesenteric Thrombosis
DUE TO

2 Days

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Resection of Gangrenous Bowel
Shock Anoxia1 Day
1 Hour

19A. DATE OF OPERATION

1-21-1965

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

See I

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Not While
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 21, 1965 to January 22, 1965,
that (I) (we) last saw the deceased alive on January 22, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

1-22-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Richard Lane

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-26-65

24C. NAME OF CEMETERY or CREMATORY

MT. CARMEL CEM.

24D. LOCATION

(City, town, or county)

(State)

5712 O'DONNELL ST. BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1965

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

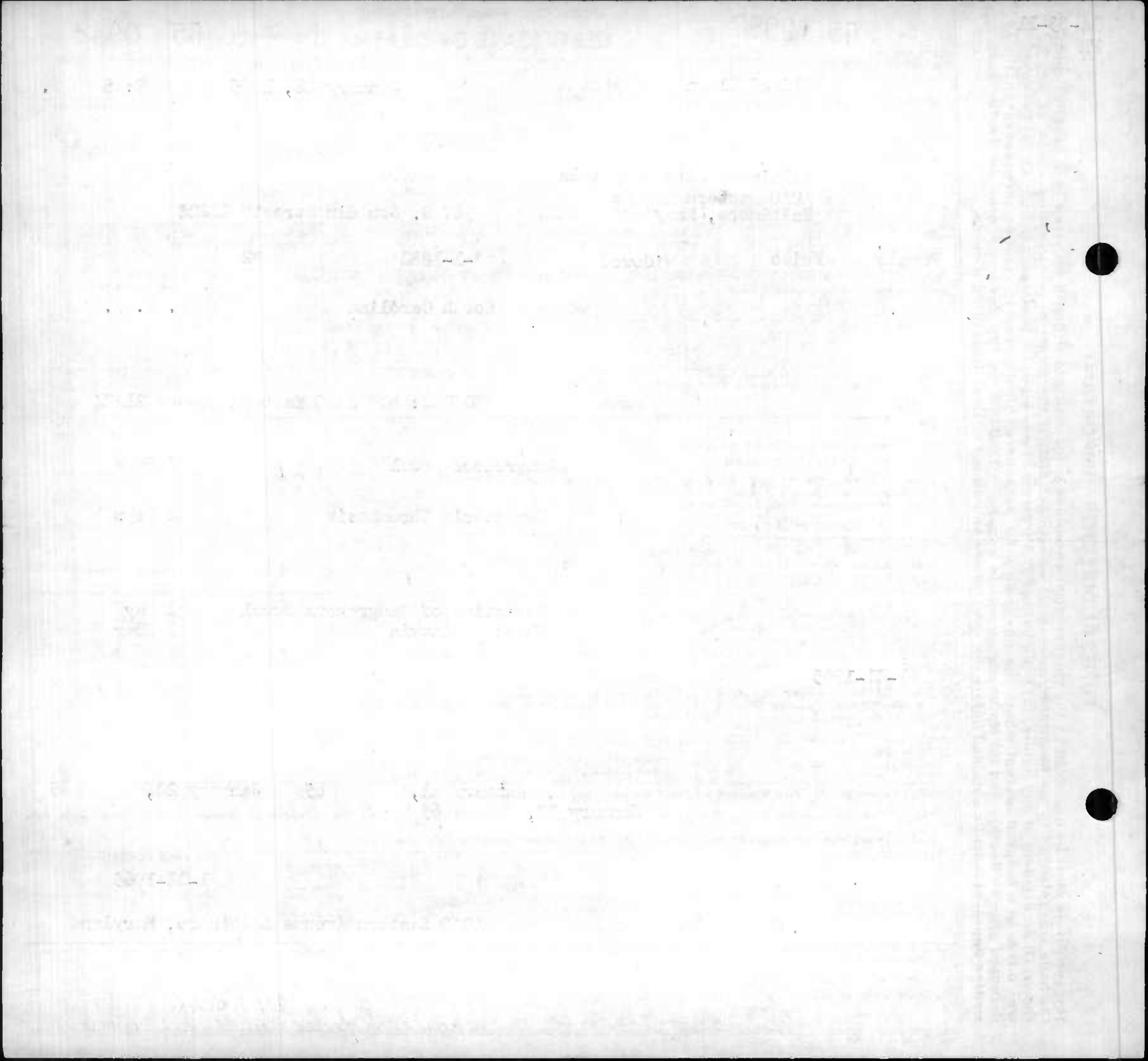
25C. FUNERAL DIRECTOR

Charles J. Geiler, 901 S. CONKLING ST. BALTO., 21224, MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0983	
BIRTH NO. 65 0983		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lavinia O. Waters</i>		2. DATE AND HOUR OF DEATH <i>1/26/65</i> <i>2:10 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>13-03</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Montebello State Hospital</i>			
		D. STREET ADDRESS (If rural, give location) <i>2311 Druidhill Ave. (2351)</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/13/74</i>	9. AGE (In years last birthday) <i>90</i>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Adolphus Oliver</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Bell Dorsey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i> <i>21-4234</i>		17. INFORMANT <i>Katherine O. Johnson, 2351 Druid Hill Ave.</i>	
18. <i>80X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute yellow atrophy of liver</i> DUE TO (B) <i>Generalized arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>1/21/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Surgeme d R foot</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>Jan. 18</i> 19 <i>65</i> to <i>Jan. 26</i> 19 <i>65</i> , that (2) (we) last saw the deceased alive on <i>Jan. 26</i> 19 <i>65</i> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <i>not</i> view the body after death.					
23A. SIGNATURE <i>Bruce H. MacPherson</i>				23B. DATE SIGNED <i>Jan. 26, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bruce H. MacPherson MD</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-29-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law, 802 Madison Ave. #1</i>	

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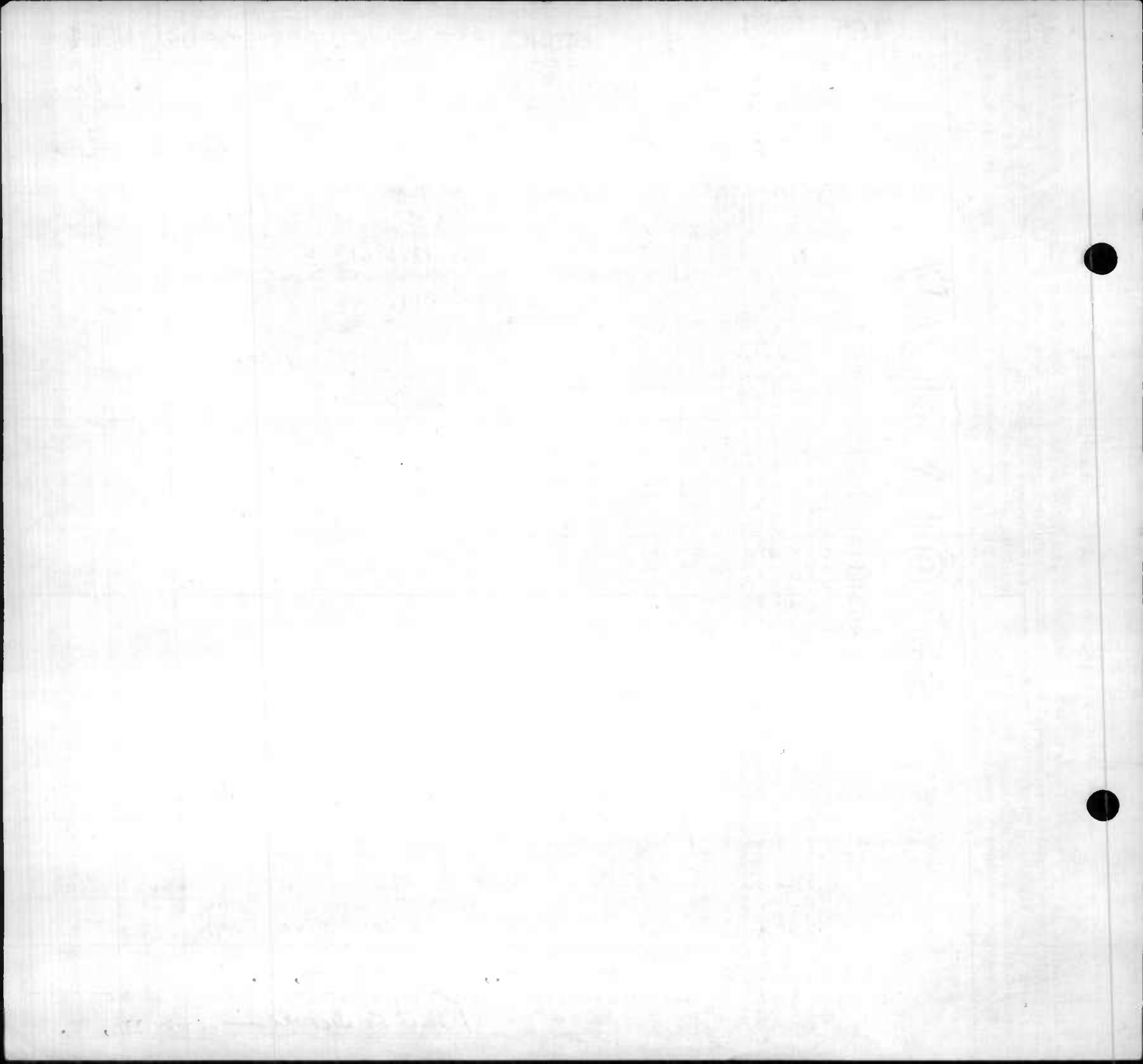
1. 10. 1954

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0984	
CERTIFICATE OF DEATH					
BIRTH NO. 65 0984		M.E. CASE NO. 1			
1. NAME OF DECEASED (Type or Print) ALLEN, Sharon			2. DATE AND HOUR OF DEATH JAN 20, 1965 7 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hosp.			A. STATE Md. B. COUNTY Howard C. CITY OR TOWN (If outside city limits, write RURAL and give township) Jessup Md. D. STREET ADDRESS (If rural, give location) Box 85 Guilford Rd.		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Dec. 17, 1961	9. AGE (In years last birthday) 3	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Robert Green		
14. MOTHER'S MAIDEN NAME Dolores Allen			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mother		
18. ADDRESS Same as pt.			19. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 340.31 meningitis, Bacterial			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 20 1965 to Jan 20 1965, that (I) (we) last saw the deceased alive on Jan. 20 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Norman Post				23B. DATE SIGNED Jan. 20, 1965	
23C. PHYSICIAN'S NAME (Type) Norman Post				23D. ADDRESS Johns Hopkins Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/65		24C. NAME OF CEMETERY or CREMATORY Asbury Cemetery.,	
24D. LOCATION (City, town, or county) (State) Jessup, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Robert L. Sumner			
25D. ADDRESS Rockville, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 0985	
BIRTH NO. 65 0985				65 0985	
CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
HALLIGAN, PHILIP J.		1-26-65 17:30 A.M.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
LUTHERAN HOSP. of Md.		MARYLAND 25-43		BALTIMORE #30	
D. STREET ADDRESS (If rural, give location)		5. SEX		6. RACE	
1917 GRINNALDS AVE		M		W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MARRIED		8-15-02		62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Dock Worker				Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		Francis A. Halligan		Mary E. Blake	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Cirrhosis of liver</i> DUE TO (B) <i>Infection hepatitis</i> DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
2				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-22-65 to 1-26-65, that (I) (we) last saw the deceased alive on 1-26-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Aideh Kobler M.D.		1-26-65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
AIDEH KOBLER M.D.		Lutheran Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-29-65		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 28 1965		Robert E. Taylor, M.D.		Howard H. Hubbard-4107 Wilkens Ave-21229	

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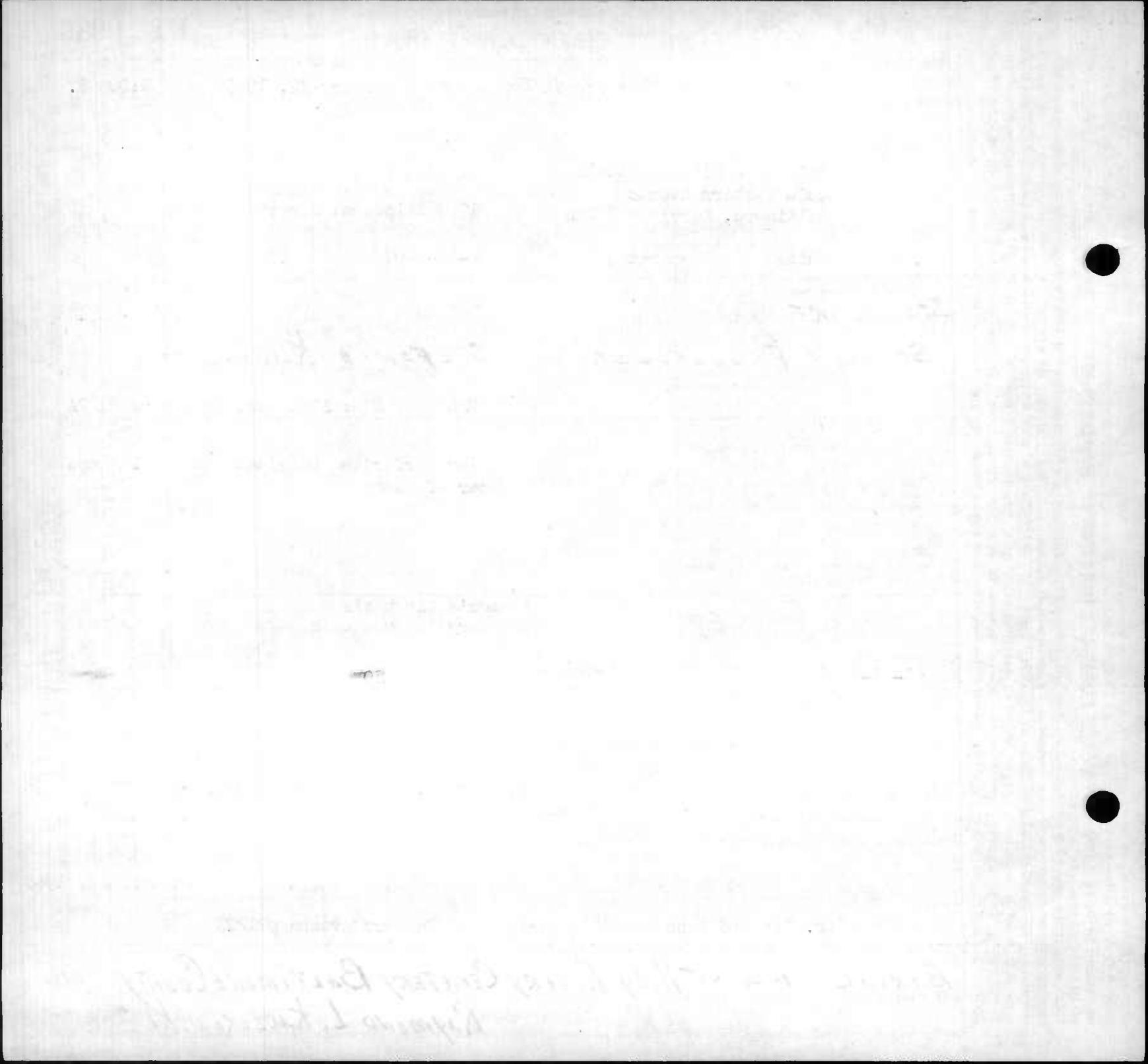
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

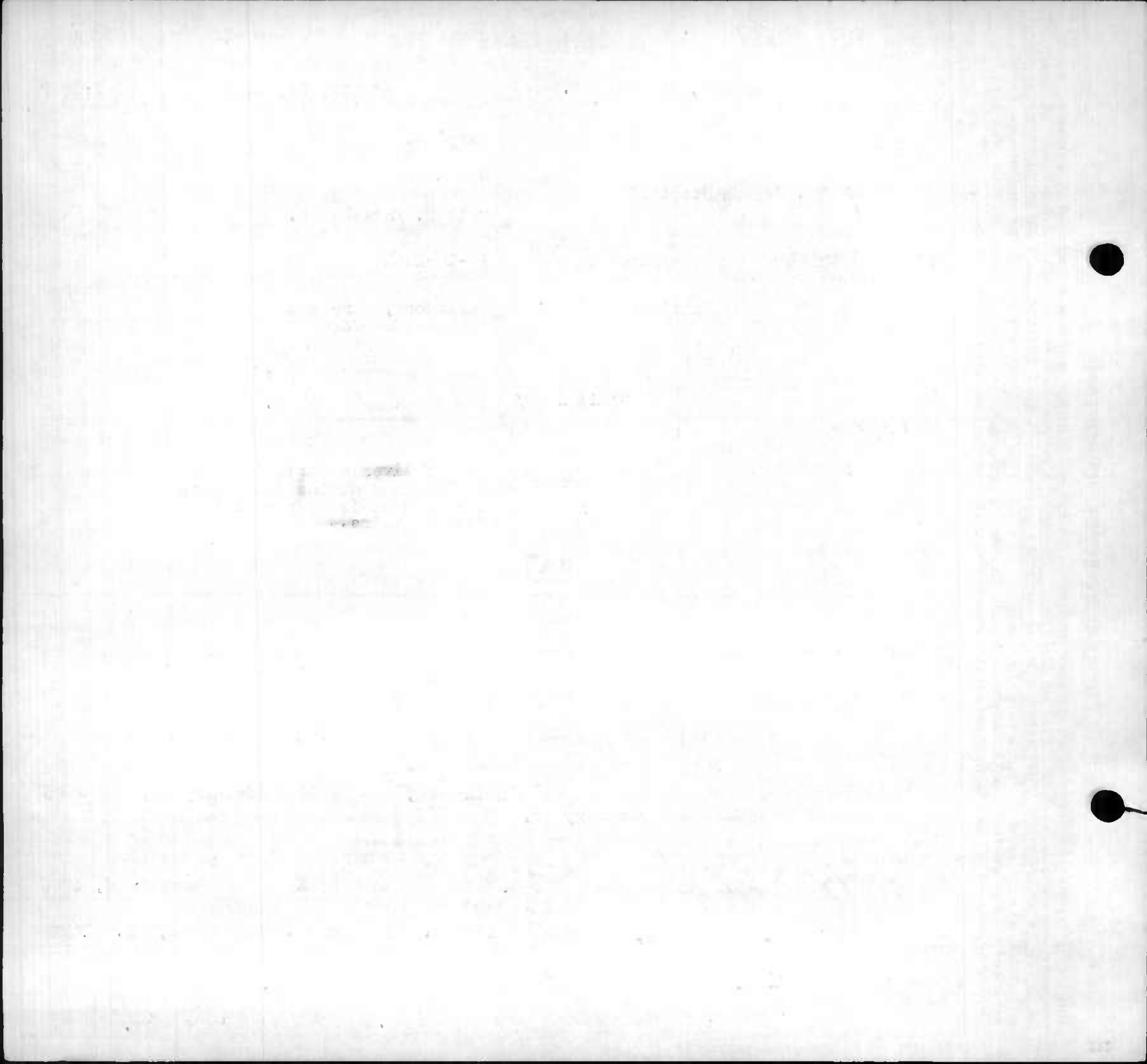
BIRTH NO. 65 0986		CITY HEALTH DEPARTMENT		Registered No. 65 0986	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Adam Franzkowski (FRACZKOWSKI)		January 22, 1965 9:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland 203			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1909 Aliceanna Street 21231			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
Male	White	Separated	8-16-1907	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STEVEDORE				Poland	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?			
STANLEY FRANZKOWSKI		U. S. A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: BCH: 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Posterior Perforated Marginal DUE TO Ulcer of Stomach		14 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Laennec's Cirrhosis Pulmonary Tuberculosis			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
1-21-1965	Peritonitis	NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 18, 1965 to January 22, 1965, that (I) (we) last saw the deceased alive on January 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Lane		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 22, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Richard Lane		23D. ADDRESS M.D. 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	1-26-65	Holy Rosary Cemetery		BALTIMORE COUNTY MD.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
JAN 28 1965	Robert E. Tarkenton	RAYMOND L. KACZKOWSKI 2625 FLEET ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

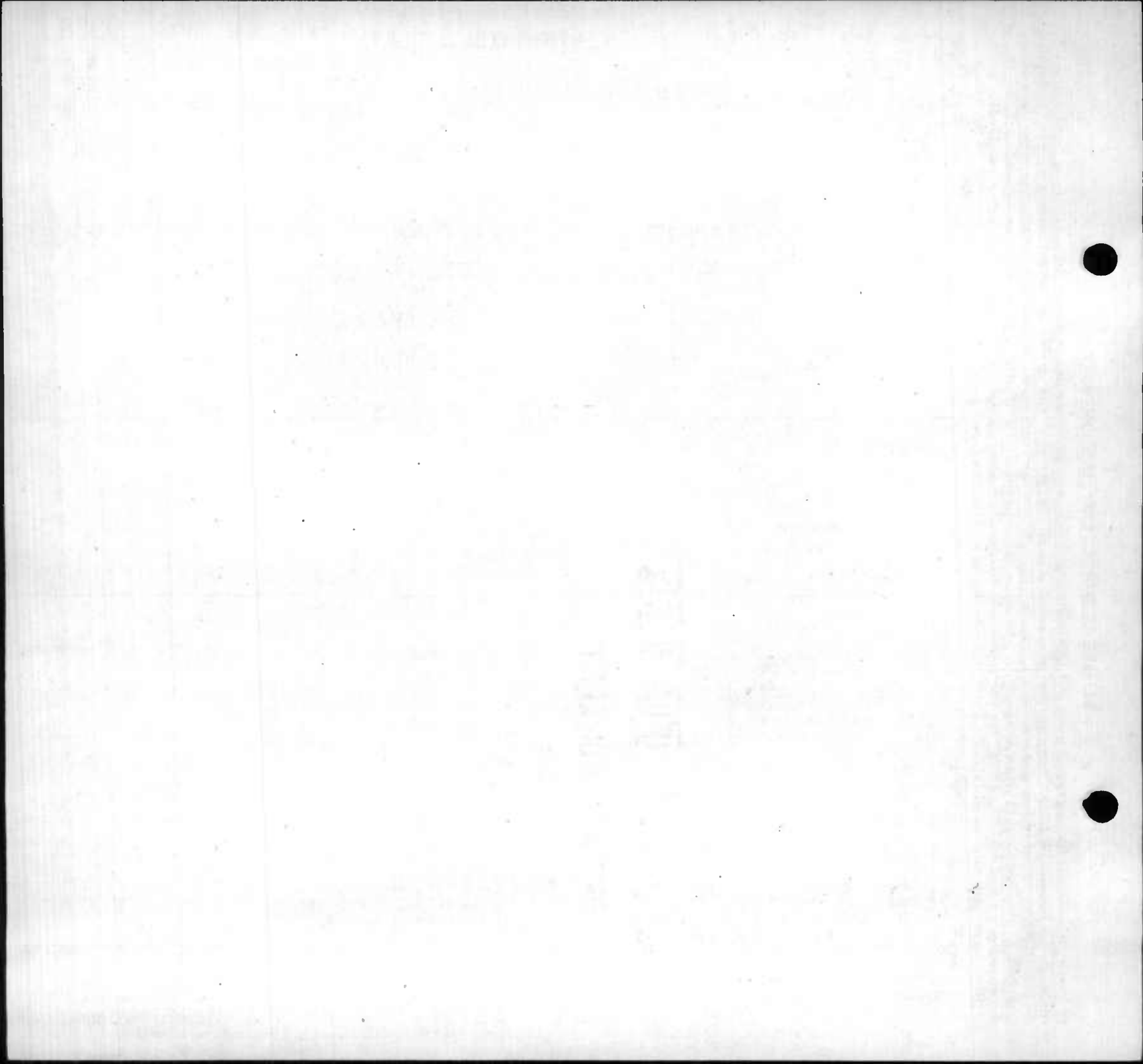
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>65 0987</u>					
BIRTH NO. <u>65 0987</u>										
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Roberts, Francis A.</u>					January 25, 1965 7:05 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>					A. STATE <u>Maryland</u>					
					B. COUNTY <u>7-03</u>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
					D. STREET ADDRESS (If rural, give location) <u>2217 E. Madison St.</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>12-18-1901</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Frank Roberts</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Huber</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-14-3031</u>		17. INFORMANT <u>Helen Roberts</u>			ADDRESS <u>2217 E. Madison Street</u>		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <u>Carcinoma of liver, metastasis to right lung and mediastinal lymph nodes; thrombosis of portal and mesenteric veins.</u>					
					(B) DUE TO					
					(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>January 23, 1965</u> to <u>January 25, 1965</u> , that (I) (we) last saw the deceased alive on <u>January 25, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>William B. VandeGrift</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>January 26, 1965</u>		
23C. PHYSICIAN'S NAME (Type) <u>William B. VandeGrift,</u>					23D. ADDRESS M.D. <u>1400 N. Caroline St., Baltimore, Md. 21213</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-29-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>			25C. FUNERAL DIRECTOR <u>Philip E. Gwach</u>			ADDRESS <u>1211 Chesaco Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

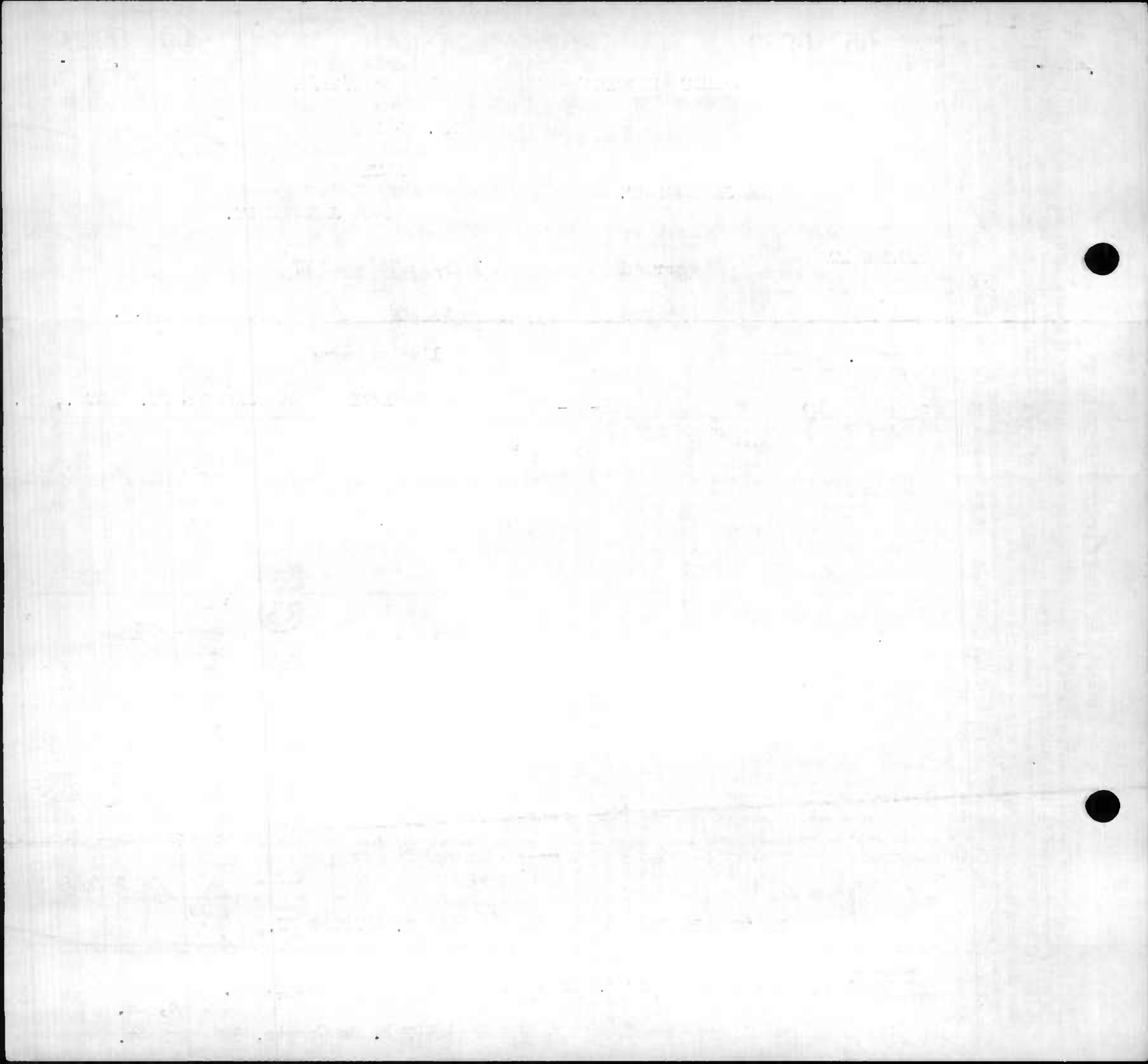
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 0988				
BIRTH NO. 65 0988									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>Katrenic, Steven Paul (Stephan P.)</i>					2. DATE AND HOUR OF DEATH <i>1/25/65 10³⁰ P M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i>					A. STATE <i>Baltimore Md</i>				
					B. COUNTY <i>7-01</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					D. STREET ADDRESS (If rural, give location) <i>523 N Potomac St.</i>				
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>9/23/02</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Europe</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>XXXXXXXXXXXX Paul Katrenic</i>					14. MOTHER'S MAIDEN NAME <i>XXXXXXXXXXXX Anna -</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-07-3140</i>		17. INFORMANT <i>Mary Katrenic 523 N. Potomac Street</i>			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <i>Cancer of the Lung with metastasis</i>				
					INTERVAL BETWEEN ONSET AND DEATH				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>1/25</i> 19 <i>65</i> to <i>1/25</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Byong Koo Kim</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>1/25/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Byong Koo Kim</i> M.D.					23D. ADDRESS <i>Franklin Square Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>1-30-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart of Jesus Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Philip E. Cvach</i>			ADDRESS <i>1211 Chesaco Avenue</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

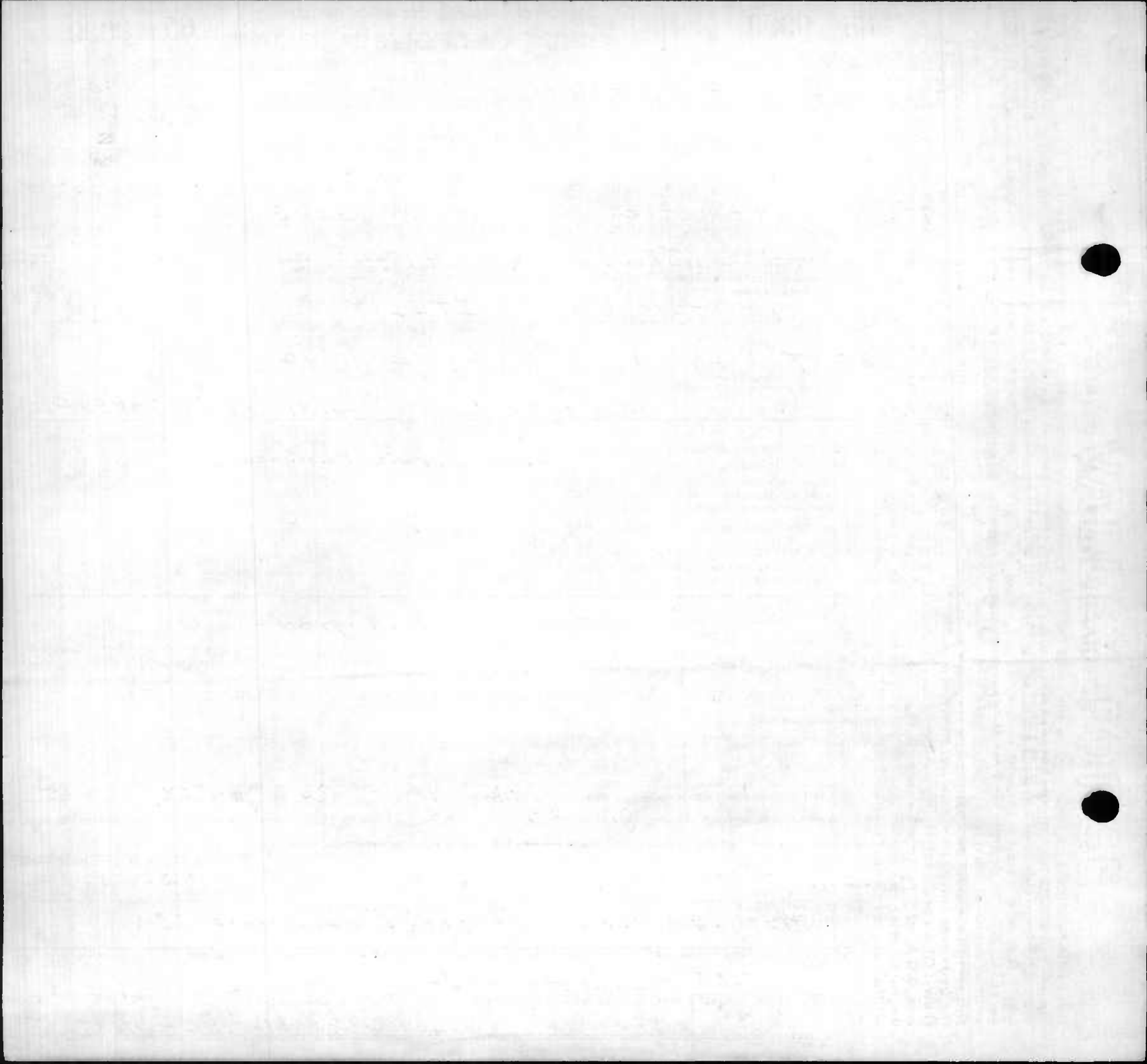
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 0989		CERTIFICATE OF DEATH		Registered No. 65 0989	
1. NAME OF DECEASED (Type or Print) HERBERT HIGGINS				2. DATE AND HOUR OF DEATH 1/21/65 10:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1404 JACKSON ST.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 21230 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1404 JACKSON ST.					
5. SEX MALE WHITE	6. RACE MALE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/19/1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James M. Higgins				14. MOTHER'S MAIDEN NAME Della Larimore					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-4037		17. INFORMANT ADDRESS ARNOLD HIGGINS 1404 JACKSON ST. BALTO., MD.					
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH		
				(B) DUE TO arteriosclerosis					
				(C) DUE TO Senility					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Parkinson's Disease					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 19 1965 to Jan 20 1965 , that (I) (we) last saw the deceased alive on January 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Isaac Miller				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 1/22/65	
23C. PHYSICIAN'S NAME (Type) ISAAC MILLER				23D. ADDRESS M.D. 1228 S. CHARLES ST.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/1965		24C. NAME of CEMETERY or CREMATORY Dorchester Memorial Park		24D. LOCATION (City, town, or county) (State) Cambridge, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Anthony P. Le Compte, 308 High St. Cambridge, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

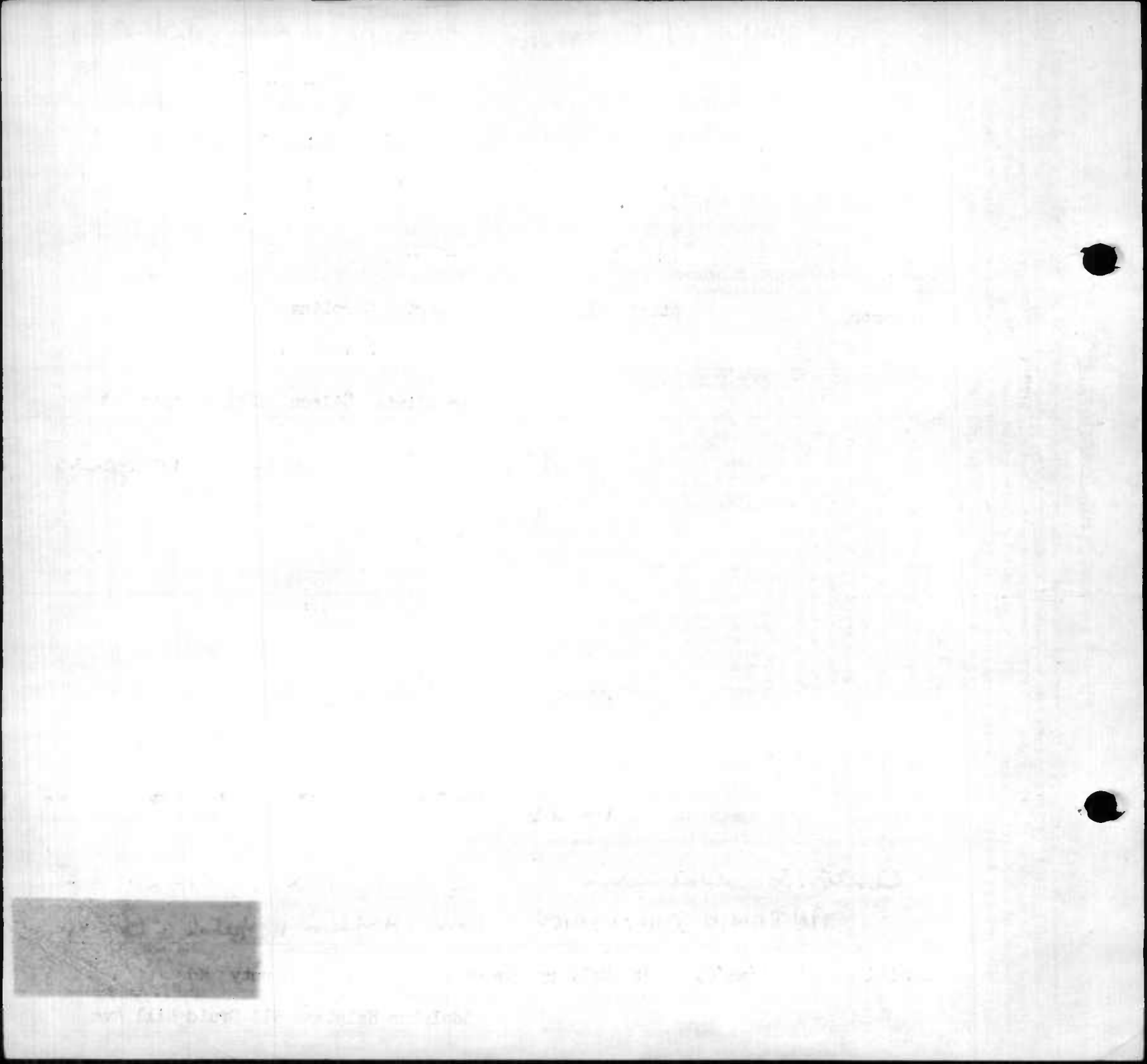
BIRTH NO. 65 0990		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 0990	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) DANTE RIGHINI				JAN. 23, 1965 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md. B. COUNTY 6-01			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE			
D. STREET ADDRESS (If rural, give location)				156 N. DECKER AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUG. 4, 1894	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SELF EMPLOYED		TAVERN		ITALY		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
NORBERT RIGHINI				GILDA BONA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
WW-1		212-34-9886		MRS. MARY RIGHINI		156 N. DECKER AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) BRONCHOPNEUMONIC COAGULATION			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				SEVERE DEBILITATION.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 1 1964 to JAN 23 1965, that (I) (we) last saw the deceased alive on JAN 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ANDREW LEMISKA				1/25-65			
23C. PHYSICIAN'S NAME (Type) ANDREW LEMISKA				23D. ADDRESS			
				2608 E. BALTIMORE ST.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1-25-65		HOLY REDEEMER CEM.		BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 28 1965		Robert E. Farley, M.D.		B. Dabrowski		2815 E. BALTIMORE ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0991	
BIRTH NO. 65 0991		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE RANSON		2. DATE AND HOUR OF DEATH 1-25-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY 12 04			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 31.			
		D. STREET ADDRESS (If rural, give location) 2231 BARCLET ST. BARCLAY ST.			
5. SEX MALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWER	8. DATE OF BIRTH 3-16-85	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME OLIVIA WILSON		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Olivia Wilson 2231 Barclay St	
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Peri-rectal abscess ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ca of prostate		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-11 1964 to 1-25 1965 , that (I) (we) last saw the deceased alive on 1-25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio Dalmerico M.D.				23B. DATE SIGNED 1-26-65	
23C. PHYSICIAN'S NAME (Type) ANTONIO DALMERICO M.D.				23D. ADDRESS Johns Hopkins Hospital, Brady	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/65		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetry	
				24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 918 Druid Hill Ave	



F. 6001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 0992

BIRTH NO. 65 0992

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAULINE M. FREY

2. DATE AND HOUR OF DEATH

JANUARY 26, 1965 1 16³⁰ A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

2731 CHESLEY AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

2731 CHESLEY AVENUE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

JUNE 23, 1886 78

9. AGE (In years
last birthday)If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ADAM LURZ

14. MOTHER'S MAIDEN NAME

JOSEPHINE SCHROEDER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-20-4469A

17. INFORMANT

MRS. MARGARET RAY

ADDRESS

SAME

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Coronary Artery dis

1 mos

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1965 to Jan. 26, 1965
that (I) (we) last saw the deceased alive on Jan. 25, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Donald Jandorf

M.D. Attending ☒ Phys.
Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

1-26-65

23C. PHYSICIAN'S
NAME (Type)

R. DONALD JANDORF

23D. ADDRESS

M.D. 6077 HARFORD ROAD, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1/29/65

24C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL CEMETERY

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1965

25B. NAME OF REGISTRAR

Robert E. Jandorf

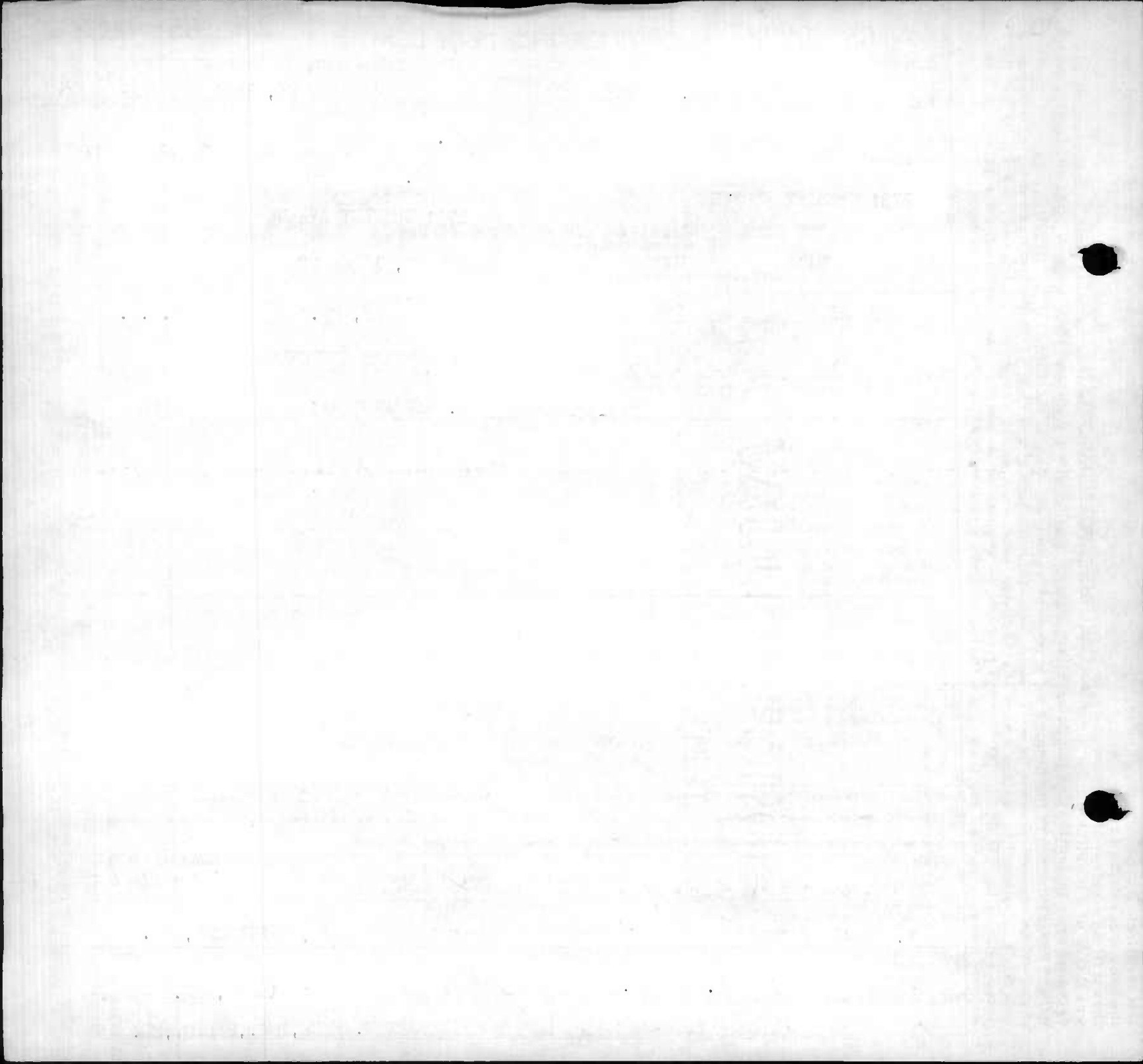
25C. FUNERAL DIRECTOR

LEONARD J. RUCK, INC., BALTO., MD.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

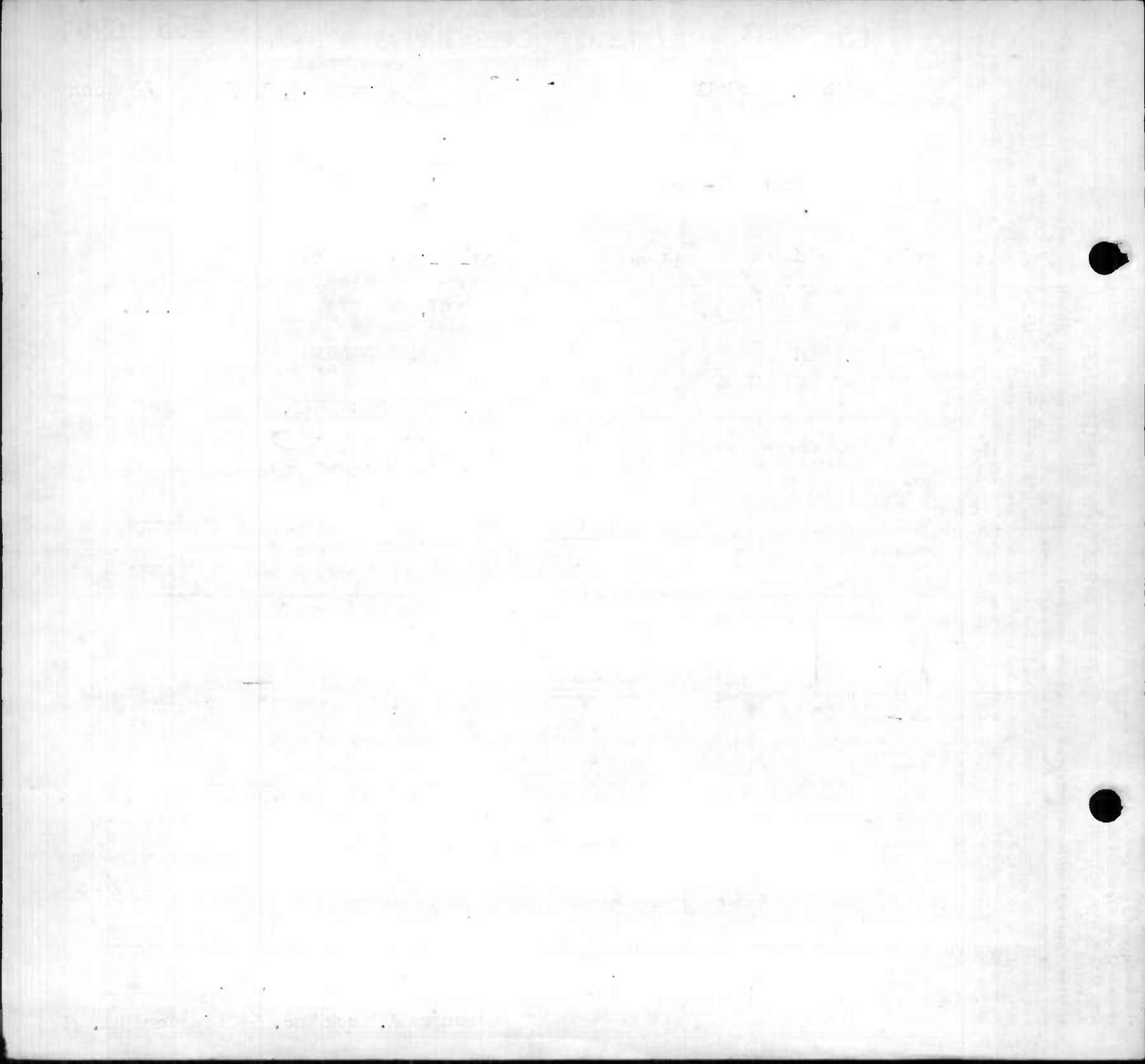
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 0993	
BIRTH NO. 65 0993					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edith R. Lobdell		2. DATE AND HOUR OF DEATH January 26, 1965 12 Noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 27-34			
FULL NAME OF HOSPITAL OR INSTITUTION House In The Pines Bel-Aire 5837 Belair Rd.		C. CITY OR TOWN (If outside city limits, write RURAL and give town ship) TROY, NEW YORK BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3703 EVERGREEN AVENUE			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-24-1885	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TROY, NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES T. MAIN		14. MOTHER'S MAIDEN NAME CAROLINE DOWNING	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. RAYMOND LOBDELL, ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD <i>Fracture of right femur</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Painful & inflamed hip</i> <i>Fracture of right hip</i>		CAUSE OF DEATH ASCVD <i>Fracture of right femur</i> <i>Painful & inflamed hip</i> <i>Fracture of right hip</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>3 days</i> <i>3 weeks</i>	
19A. DATE OF OPERATION 1 Jan 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture of right hip</i>		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? 3703 Evergreen Ave		21D. TIME OF INJURY (APPROX.) 12 29 64 230		21E. INJURY OCCURRED White AI <input type="checkbox"/> Not White AI Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>fell trying to stand up.</i>		22. I certify that (I) (this hospital) attended the deceased from Jan 18 1965 to Jan 26 1965 , that (I) (we) last saw the deceased alive on Jan 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Robert E. Farley</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/27/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/29/65		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		25D. ADDRESS 5305 Harford Rd. #14			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 0994				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0994	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Kendall, Viola C.</i>				2. DATE AND HOUR OF DEATH <i>1/26/65 5:31 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>md.</i>		B. COUNTY <i>26-02</i>	
5. SEX <i>F</i>				6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		8. DATE OF BIRTH <i>6/17/91</i>		9. AGE (In years last birthday) <i>73</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>John C. Clark</i>	
14. MOTHER'S MAIDEN NAME <i>Irene Little</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Martin C. Kendall</i>				ADDRESS <i>347 S. Robinson</i>			
18. <i>381X I</i>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Cardiac arrest</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>brain stem necrosis</i>			
				(C) <i>Cerebrovascular accident</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/13</i> 19 <i>62</i> to <i>1/26</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>1/26</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert W. Ireland</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/26/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland</i>				23D. ADDRESS <i>Montebello State Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/30/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadow Branch Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Westminster Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		ADDRESS <i>Balto 14 Md.</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 0995	
BIRTH NO. 65 0995							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)		LODA AMELIA STINE				2. DATE AND HOUR OF DEATH 1/26/65 10³⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 27-10					
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #12					
		D. STREET ADDRESS (If rural, give location) 521 ROSSITER AVENUE					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 3/21/86	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. HARCLERODE				14. MOTHER'S MAIDEN NAME SARAH C. HARCLERODE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-78-0474		17. INFORMANT ADDRESS AUMH CHART			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema		(A) DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Myocardial infarction		2 wks			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 1/20/19 65 to 1/26/19 65 , that (I) (<u>we</u>) last saw the deceased alive on 1/26/19 65 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.							
23A. SIGNATURE A. Laird Bryson				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/26/65	
23C. PHYSICIAN'S NAME (Type) A. LAIRD BRYSON				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/30/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto.		ADDRESS 14 Md	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 0996</u>	
BIRTH NO. <u>65 0996</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary C. Faulhaber</u>		2. DATE AND HOUR OF DEATH <u>January 26, 1965</u> <u>5:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2812 Echodale Avenue</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-06</u>			
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>				8. DATE OF BIRTH <u>Aug. 25, 1881</u> 9. AGE (In years last birthday) <u>83</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
13. FATHER'S NAME <u>Edward George Grape</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Johanna Ziegler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Joseph Faulhaber</u> ADDRESS <u>Balto., Md.</u>	
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <u>Hypertensive Cardiovascular</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
				(B) DUE TO		(C) DUE TO	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>154 years</u> 19 <u>to Jan 26</u> 19 <u>65</u> . that (I) <u>lost</u> saw the deceased alive on <u>Dec. 28</u> 19 <u>64</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.							
23A. SIGNATURE <u>James E. White</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>1/27/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>James E. White</u>				23D. ADDRESS <u>5214 Harford Rd. Balto 14, Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/30/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Faulhaber M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u>		ADDRESS <u>5305 Harford Rd.</u>	

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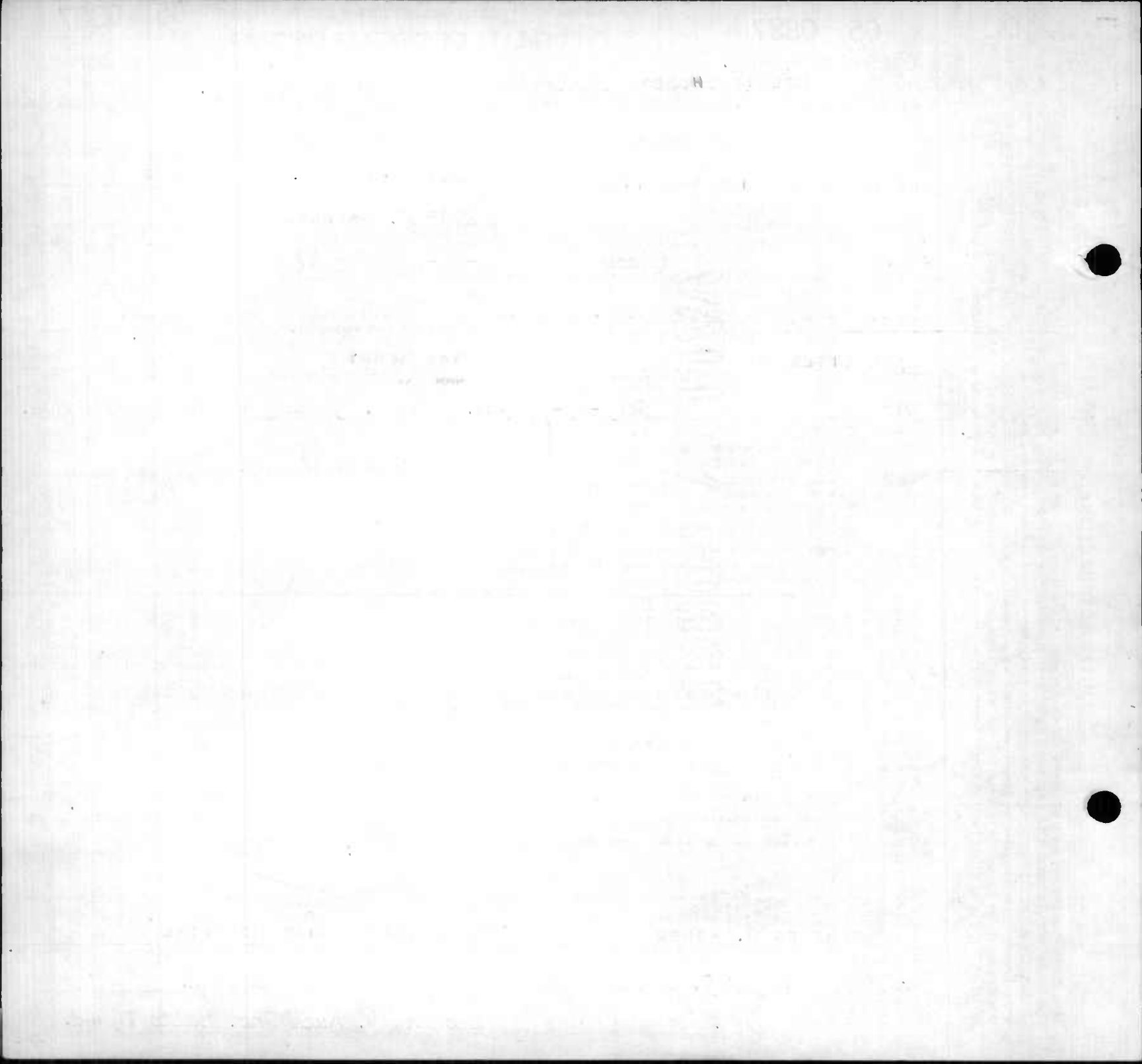
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 0997</u>	
BIRTH NO. <u>65 0997</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>E.</u>					
1. NAME OF DECEASED (Type or Print) <u>NELLIE SHOREY Shorey</u>		2. DATE AND HOUR OF DEATH <u>9:35 1/27/65.</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> (If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE CHARLES</u>			
		D. STREET ADDRESS (If rural, give location) <u>2715 N. CHARLES</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>6-29-07</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Army Chem. Center</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>JOHN EISER</u>		14. MOTHER'S MAIDEN NAME <u>MYRA HENRY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-9404</u>		17. INFORMANT ADDRESS <u>Mr. John W. Eiser 3302 Westerwald Ave.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Mital insufficiency</u> DUE TO (B) <u>Coronary artery Disease</u> DUE TO (C) <u>Interosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>longstanding</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>1/25/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mital insufficiency</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>12/3/64</u> 19 <u>to</u> <u>1/27</u> 19 <u>65</u> , that we (we) last saw the deceased alive on <u>1/22/65</u> 19 <u>and</u> that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hewes D. Agnew</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/27/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>HEWES D. AGNEW</u>		23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/30/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto 14 Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												
CERTIFICATE OF DEATH					Registered No. <u>65 0998</u>							
BIRTH NO. <u>65 0998</u>		M.E. CASE NO. <u>65 0998</u>			1. NAME OF DECEASED (Type or Print) <u>Steigers, Mrs. Alice T.M.</u>					2. DATE AND HOUR OF DEATH <u>1-27-65</u> <u>1</u> <u>755</u> A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mercy Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1651 Burnwood Rd.</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>		8. DATE OF BIRTH <u>6-23-84</u>	9. AGE (In years last birthday) <u>80</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Henry McManus</u>					14. MOTHER'S MAIDEN NAME <u>Alice Minahan</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>218-10-6231</u>		17. INFORMANT <u>Mrs. Dolores Murphy</u>				ADDRESS <u>Same</u>	
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Coronary Heart Failure</u> DUE TO (B) <u>Myocardial Damage</u> DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.												
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <u>1-17-65</u> 19 to <u>1-27-65</u> 19, that (I) (we) last saw the deceased alive on <u>1-26-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE <u>Perry S. Shelton</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1-27-65</u>				
23C. PHYSICIAN'S NAME (Type) <u>Perry S. Shelton</u> M.D.					23D. ADDRESS <u>Mercy Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/30/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto.</u>			ADDRESS <u>14 Md.</u>			

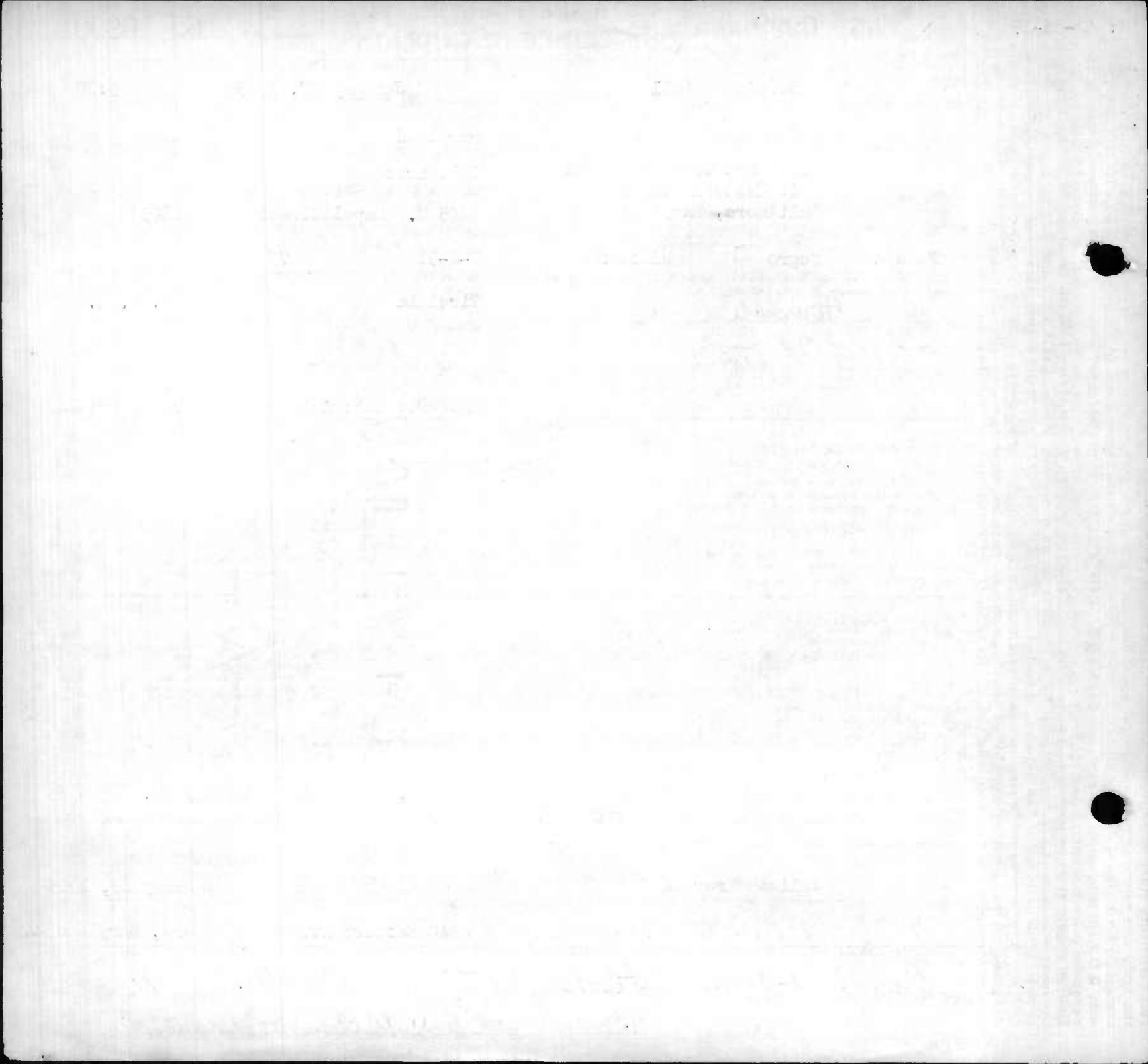
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 0999	
BIRTH NO. 65 0999					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Bessie Hall			2. DATE AND HOUR OF DEATH January 27, 1965 3:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1605 N. Chapel Street 21205		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-4-91	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Lewis Chatman			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 11, 1964 to January 27, 1965 , that (I) (we) last saw the deceased alive on January 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julius Krevans M.D.				23B. DATE SIGNED January 27, 1965	
23C. PHYSICIAN'S NAME (Type) Julius Krevans M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 24	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-1965		24C. NAME of CEMETERY or CREMATORY Not Cahay Cent	
24D. LOCATION (City, town, or county) (State) Brooklyn Md		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Cheryl Wilson 1001 Blandy Ave			



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65 1000 BALTIMORE CITY HEALTH DEPARTMENT 65 1000

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **ROSSIE MORRIS**

2. DATE AND HOUR PRONOUNCED DEAD **January 26, 1965 2:50 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore 1901**

D. STREET ADDRESS (If rural, give location) **521 N. Fulton Avenue**

5. SEX **male**

6. RACE **colored**

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH **July 21-1895**

9. AGE (In years last birthday) **69**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Post Electric Retired**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Middlesex Co Va**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **John Morris**

14. MOTHER'S MAIDEN NAME **unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **yes**

16. SOCIAL SECURITY NO. **212-05-9309**

17. INFORMANT **Jarman W. Morris**

ADDRESS **same**

18. **4-2-2-1** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) **Congestive heart failure**

(B) **Arteriosclerotic cardiovascular disease**

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Rudiger Breitenecker** M.D.

EXAMINER'S NAME (Type) **Rudiger Breitenecker**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **1-27-65**

23A. BURIAL CREMATION, REMOVAL (Specify) **1-30-1965 Buried**

23B. DATE

23C. NAME of CEMETERY or CREMATORY **Arbutus Cent**

23D. LOCATION (City, town, or county) (State) **Balto Md**

24A. DATE REC'D BY HEALTH DEPT. **JAN 28 1965**

24B. NAME OF REGISTRAR **Robert E. Farber M.D.**

24C. FUNERAL DIRECTOR **Choy B. Wilson 1000 Brantly Ave**

ADDRESS

VS 151-REV. 1/1/65

WALTER J. JONES

WALTER J. JONES